VOLUME 56 • NUMBER 4 • APRIL, 1960

BOARD OF PUBLICATION

Robert W. Kimbro, M. D., Cleburne, Chairman
G. V. Brindley, M. D., Temple
Byron P. York, M. D., Houston
Troy A. Shafer, M. D., Harlingen
J. B. Copeland, M. D., San Antonio

•

F. W. Yeager, M.D., Corpus Christi
President

•

EDITORIAL AND BUSINESS OFFICES

1801 North Lamar Blvd., Austin
Telephone: GReenwood 7-9447
C. Lincoln Williston, Executive Secretary
Harriet Cunningham, Managing Editor
E. Maxwell Jones, Business Manager
Kenneth P. Knopp,
Advertising Manager

•

PRINTING OFFICES

c/o Stafford-Lowdon Company
1114 West Daggett, Fort Worth 1

•

Subscriptions: $3 per year for members; $6 for nonmembers; $7 for foreign. Single copy: 75 cents.

Copyright 1960 by the Texas Medical Association. Owned and issued monthly by the Association.

Dr. May Owen

Dr. May Owen, Fort Worth, became the ninety-fifth President of the Texas Medical Association during the April annual session in her home city. She is the first woman ever to have been so honored by the Texas Medical Association, and is the second woman physician to be so honored by any state medical association in the United States. (Her predecessor: Dr. Leslie S. Kent, 1947-1948 president of the Oregon Medical Association.)

One of a large family, Dr. Owen was born on a farm in Falls County. Long hours and hard work have been her way of life since she earned part of her medical school expenses as a part-time medical technician. She received her bachelor of arts degree in 1917 from Texas Christian University, obtained her medical degree in 1921 from the Louisville (Ky.) Medical School, and did postgraduate work at the Mayo Clinic Department of Surgical Pathology and New York Bellevue Hospital's Medical Examiners Department.

Since 1928, she has been a pathologist—is now chief pathologist—for Terrell's Laboratories in Fort Worth. Her deep interest in her work has led to a number of published papers, and she has received awards for two specific pieces of investigation.

The first of these awards, an honorary doctor of science degree from Texas Christian University in 1936, was for what she has said she feels to have been her most important piece of work: discovery that a talc powder then being used in surgical gloves was not absorbable and that a speck of it, falling into a wound during an operation, might cause scar tissue, adhesions, and peritonitis. (Today a major

national pharmaceutical house manufactures a glove powder which is absorbed if small amounts of it sift into an incision.) Her second honor of this sort came to Dr. Owen in the early 1950's after she tramped across Tarrant County pastures with veterinarians to study the mysteries of a cattle disease now recognized and treated as chloro-naphthline.

Her honors through the years have been many. The most recent include her 1959 designation as a "distinguished alumna" by the Texas Christian University Ex-Students Association, which awarded her a plaque for her "contributions in the field of medicine and her devotion to her fellow man," and her 1960 appointment to the Governor's Advisory Committee for the forthcoming Texas Conference on Aging and the White House Conference in 1961.

During the April annual session of the Texas Medical Association, also, she was named an honorary life member of the Woman's Auxiliary in a surprise luncheon ceremony.

When Dr. Owen was elected first woman president of the Tarrant County Medical Society in 1947, the only dissenting vote was her own. Again, in 1952, this predominantly male group awarded her its annual "Gold Headed Cane," traditionally reserved for "a fellow admired by other men. A doctor's doctor."

An outstanding pathologist of the Southwest, Dr. Owen is a past president of the Texas Society of Pathologists and in 1958 received its George T. Caldwell Award. In 1951 she was named one of Texas' nine outstanding women and honored at the second annual Party of the Year in Mineral Wells. The Fort Worth Altrusa Club chose her as "First Lady of Fort Worth" in 1948.

Dr. Owen was chairman of the Texas Medical Association's Council on Scientific Work for 9 years, and was a member of its Committee on Scientific Exhibits when she was named President-Elect last year.

She is a past president of the Thirteenth District Medical Society and of the Tarrant County Unit of the Texas Division, American Cancer Society; in 1959 she became a director of the Texas Division. She has been made an honorary member of Delta Kappa Gamma, the teachers' group, and a recipient "sister" of Alpha Kappa Kappa men's medical fraternity. Her favorite civic duty is her trusteeship of the Texas Boys' Choir.

Dr. Owen is a member of such groups as the American Medical Association, Southern Medical Association, College of American Pathologists, American Society of Clinical Pathologists, American College of Physicians, and the United States Committee of the World Medical Association. She regularly attends meetings of these organizations and other professional conferences throughout this country and abroad.

Despite the hard work required by Dr. Owen's professional standards and the esteem she receives from male colleagues as a "good fellow," Dr. Owen is a womanly woman with a soft tone of voice. Unmarried, she has lived for years in the Hotel Texas of Fort Worth, eating most of her meals in the hotel coffee shop.

Although Dr. Owen has no children of her own, she does have a family which she has referred to as her professional "life insurance." It includes the many medical students whom she has helped, or is now helping, through medical school and to whom she writes friendly notes along with every check.

As President of the Texas Medical Association, Dr. Owen succeeds Dr. Franklin W. Yeager of Corpus Christi. Dr. Yeager has said of his successor: "She is an outstanding Woman, an outstanding Scientist, and an outstanding Doctor."

One watching Dr. Owen quietly at work in medical groups becomes aware of some of the attributes that have brought her recognition from her fellows and will serve her well in her newest position of leadership. She is a hard worker and does not expect more of others than she demands of herself. She has an urgent sense of devotion to duty. She has a keen inter-

est in many things and many people. She has the real affection and respect of those who know her. Withal she has a genuine humility and modesty that will credit successes achieved during her administration to anyone but herself. Yet only she will be surprised if this turns out to be an unusually fine year for the Texas Medical Association—everyone will be working with "Dr. May" to make it so.

Reducing Health Care Costs

The American Medical Association's recent decision to appoint a "Commission on the Cost of Medical Care," the purpose of which is to delve into every phase of medicine where cost or spending is involved, was welcomed by members of the Texas Medical Association Committee on Health Insurance. We have been especially concerned in that the rising costs of over-all care have resulted in the concomitant increase in health insurance premiums with the ever present danger of pricing health insurance out of the market for many of our income groups to whom it is the most practical way of meeting health costs. We members of the committee who have studied this problem at a state and local level for the past 2 years are of the unanimous opinion that the futures of the voluntary health insurance industry and the private practice of medicine are inseparable. More pointedly stated, we feel that unless we can aid in establishing and maintaining a vigorous, healthy, voluntarily financed program to cover adequately the health costs of practically all of our citizens, the private practice of medicine as we know it will disappear from the face of our land. This void will almost certainly be filled by a government sponsored and financed plan.

We find little consolation in the numerous reports by medical economists stating that medical costs have not risen at the same rate over the past 20 years as have costs of automobiles, hair cuts, liquor, motor boats, and similar items. Whereas a patient may almost gleefully budget his income to pay for a new automobile, he finds the payment of any of his income towards the cost of sickness outright distasteful.

Fortunately, we, as physicians, have at our command one method of exerting partial control over skyrocketing costs. Since only we can admit patients to the hospital and write their orders, we have at our finger tips an opportunity to keep costs reasonable and discourage much of the over-utilization and abuses of health insurance without compromising the high quality of medical care.

We should have the courage to refuse to acquiesce to unreasonable demands by patients for unnecessary and usually costly procedures and laboratory tests as well as "rest cures" in the hospital. By reducing these costs and keeping our own fees within reason, we can strike a positive blow at the ever present threat of further federal intervention in the practice of medicine.

—G. S. AHERN, M.D., Corpus Christi,
Member, Texas Medical Association
Committee on Health Insurance.

Pharmacist's Role in Medicine

Since the advent of the sulfa drugs followed by the antibiotics, hormones, tranquilizers, and a host of other remedial agents developed since World War II, the problem of keeping up with new drugs has become a difficult one for the physician.

Aside from the fact that many new categories of drugs have been introduced into medical practice in the last 15 years, the number of drugs in each category increases almost daily. Added to this is the problem of the multiplicity of drug products containing the same basic chemical compound. All of this means only one thing, the necessity for the physician to spend a considerable amount of time each

Members of the Texas Medical Association and those in the professions related to medicine are invited to submit contributions to the Editorial and Current Editorial Comment sections of the Journal. Manuscripts should be 350 to 750 words in length.

week in reading new product literature and in discussing these new products with the medical service representatives and the pharmacists.

Some pharmacists have realized their responsibility to the physician in this connection and have designated an area in their store for new products. Very often an office is provided in the prescription area where the physician may compare the new drugs and discuss certain aspects of them with the pharmacist.

These products are arranged according to therapeutic action groups so that the physician can study the new products offered in a given action group and decide on the best medication for his patient. In many cases certain undesirable side effects are present in one product and not in another, or one product may contain a combination of drugs to give a combined therapeutic effect and in this way are tailor made for treating his patient. Literature is provided on each product and thereby made available to the physician.

The new drug products find their way to the case as they are released from the manufacturer and introduced to the physician by the medical service representative. They are removed when they have become firmly established in medical practice. Other new drugs in turn find their way to the case, and the process is a continued one.

The pharmacist must become well acquainted with the new drug case and be ready to discuss the merits of each drug with the physician. He must be informed concerning the pharmacologic and therapeutic usefulness of the drug, the side effects, the dose, and the mode of administration and, in addition, be able to compare the drugs of a similar action on the basis of chemical structure, rate of absorption, and stability. Also, the pharmacist must be able to discuss the cost of each drug product in terms of the ultimate price of the prescription to the patient. Training in the colleges of pharmacy prepares the pharmacist to act as a consultant to the physician. In this connection the pharmacist has not only an opportunity but a responsibility as well to hold up his end of the medical health team. The role of the pharmacist today depends more on what he knows than on what he does.

—NOEL M. FERGUSON, Ph.D., Houston,
Dean, College of Pharmacy,
University of Houston.

A Reminder: Elections are Earlier this Year May 7

This is to remind you that good government begins at the local level. The shaping of things to come definitely lies in the hands of the people, and this includes all of us.

Be informed. Study the issues. Know the candidates. Check their records. Actively participate. Attend your precinct meetings. VOTE.

Our government is exactly what we choose to make it. It will suffer if we fail to exercise our rights and *duties* as citizens.

You have never failed to assume your responsibilities as physicians. Neither should you fail to assume your responsibilities as citizens.

You are physicians—but you are citizens first.

—PHILIP R. OVERTON, LL.B., Austin.

President's Page

1960-1961 TEXAS MEDICAL ASSOCIATION

DR. OWEN

It is with true humility that I begin this year of service. A review of the problems and work of the Texas Medical Association under the leadership of the 12 most recent presidents has left little for the thirteenth to work for, or say, that will not be repetition.

With the very able help of the officers, councils, and committees to carry on programs already in operation for the members of our great state Association, we will push forward.

The medical educational programs of Texas are many and varied. In addition to the district programs, there are more than 20 specialty societies with scientific meetings including several one day intensive study programs (general practice, heart, and cancer) and three large postgraduate medical assemblies to supplement the scientific programs of the TMA annual session, which also includes specialty groups.

The doctors of Texas are extremely fortunate in the availability of these excellent teaching facilities.

With this program, there is no reason for the physician to remain the model of his graduation year, for his educational status can, with little effort, progress in keeping with the rapid advances in all phases of medicine.

Finding time for additional activities is a problem for any professional person; but as key people we should be ready and willing to assume responsibility in the interest of better medicine. In this day and age, we pool everything for the state of efficiency, but somehow along the way, many of us may have forgotten to pool our energies in a common effort that will make for better medical care of the patient.

Let us trim our candles so they will give more light to see the problems of our own profession.

May Owen

Can Doctors Be *FREE* in a Planned Society?

BRUCE ALGER **Dallas, Texas**

Physicians need to tell Congressmen their views not only on such legislation as the Forand bill but also on other measures which are equally vital to their interests as free Americans. Doctors need to be active in politics, in election of representatives who believe in the free competitive system and will vote to sustain it when the chips are down.

HAD I NOT spoken at the Conference of County Medical Society Officials, chances are I'd have heard from a lot of the participants shortly anyway. For, as physicians well know, a determined drive is under way to force the House Ways and Means Committee to report out the Forand bill for consideration on the floor of the House of Representatives. Early in January, and as quickly as Congress convened, the Machinists Union and a number of other such organizations began exhorting their members to flood Congressmen, and particularly us members of this important committee, with mail demanding enactment of this legislation.

Probably no group is better informed on either the provisions or the implications of that particular measure than are you members of the medical profession.

Moreover, I'm confident that the doctors are going to muster a letter writing campaign of some magnitude too. Last year a good many physicians took the time to tell me in some detail of their feelings about this one bill.

And there's the rub. This good right arm of mine could hardly carry the correspondence I received from doctors, their associates, and their families concerning this proposal in which they had an obvi-

ous and vital interest. But in a year which saw a grimly embattled minority in Congress and a determined President striving to stave off one scheme after another every bit as dubious and ill advised as the Forand bill, during such a year the fingers on this left hand could easily number the doctors who troubled to discuss with me their views and opinions on other legislation every bit as vital to their interests as free Americans.

I leave it to each physician to ask yourself whether or not you made your voice heard at all, to your representatives in the Legislature or the Congress last year. And to those of you who did, did you write or wire about any subject other than the one or two in which you had an immediate and personal stake?

Returning to the machinists' publication for a moment, let me point out they are decidedly pushing the Forand bill—but they are demanding federal money for our schools, so-called aid to depressed areas, a hike in the federally imposed minimum wage, and the like. They have long urged their members to judge a representative's performance not on one "gut" issue, but by his votes on a broad range of questions in which they believe they have a long range interest. In this, the unions, and many other groups have demonstrated a political sophistication far greater than any displayed by their fellow citizens in business and professional groups.

ACTION IN POLITICS

Now what am I doing—inviting or even urging a deluge of mail to my office? Not at all! Since I'm trying to represent what I'm told is currently the most populous congressional district in the nation, I'm afraid we're getting more mail right now than we can properly handle. I am suggesting that you make your political weight felt, in the only way it really counts. It is all but futile anyway for professional or business people to try to change the mind of someone already in office and committed to an opposite viewpoint or to a bill you may find obnoxious. If you're to be at all effective in shaping the legislation and guiding the system under which we'll all live, you had better get active—really active in the process by which our representatives are selected in the first place. There's no need for fancy words—it's your responsibility and mine to get active in the art of self-government. More plainly—in politics.

William Penn, I believe, is credited with saying that "if men will not rule themselves they will be ruled by tyrants." For my money, Ben Franklin paraphrased it more bluntly in warning us that each God given right implies a moral duty and responsibility. He said, "if men will not be governed by God, then by God, they will be governed."

The only way we can assure that the principles we hold most dear will prevail is by seeing to it that men equally dedicated to those principles are elected to public office. This calls for education and public persuasion.

When I have concluded, I hope I will have aroused your interest, as doctors, in taking a greater interest in politics because the rest of us need your help in keeping our society free so that you may remain free. I will point out to you where I believe we stand at the beginning of this second session of the eighty-sixth Congress and what Congress is likely to do. When I have finished I hope that you may be inspired to do something more than you have ever done to arouse public interest to the dangers which face our free competitive system so that we may elect more representatives who believe in this system and who will vote to sustain it when the chips are down.

It makes no difference how conservative a representative talks when he is back home in Texas, or wherever his district is. It is the way he votes on these issues when they are presented to Congress that counts and exposes his real philosophy. I have available the documentation of the voting record of all the members of the House and Senate as compiled by the Machinists Union. It may be a surprise to see how nearly some of our Texas members come within 100 per cent according to this tabulation of liberal, or welfare program, votes. Incidentally, my score with the Machinists, Americans for Democratic Action, and others of like mind, is a big fat zero (on issues just as dangerous as the Forand bill).

Unless we can begin to move toward getting more representatives in Congress who believe as we do, in the free competitive system, I warn you that that system is in danger. In my opinion 1960 is definitely a year of decision.

SUPPORT OF FREE COMPETITION

Recently we have read many prognostications of what is going to happen in the Sixties—in our political life, in our economic life, in the material things which are supposed to make living so much more wonderful and easy. I hope all the rosy predictions will come to pass and that we will be able to make a living with less physical effort, that we will have greater opportunities for leisure and all the fine inventions which will make those leisure hours so exciting. But we will make this remarkable progress only in a free society. We cannot do it under socialism, in a system where individual initiative is stifled and where the government siphons off all

the incentives which inspire free men to dream and build and progress. I am confident that unless we preserve the free competitive system as we know it, and unless we face up to this critical year of 1960, the first of this fabulous decade, then the other nine years won't matter much because we may well lose our freedom and will be unable to bring about the development of these remarkable predictions.

We must realize that we cannot continue to operate in a society that is half free and half socialist. We just can't be a little bit pregnant. Believe me, if we conceive, we are going to bring forth the child, and I am sorely afraid that we have already had too dangerous a flirtation with socialist programs and schemes. It is up to you and it is up to me whether or not we are going to encourage this romance to the danger point. And if we travel down this primrose path in fields not directly related to

Bruce Alger of Dallas, Congressman from the Fifth District of Texas, presented this address at the Conference of County Medical Society Officials sponsored by the Texas Medical Association in Austin on January 16, 1960.

medicine or in areas where you are not immediately affected, we will drag you with us because we cannot continue to create welfare programs and planned economy in a few areas without eventually going all the way, including the medical field.

Goodness knows, our free competitive system has served us well. Our people receive the benefits of the best medical care in the world because the medical profession has been allowed to operate in a free society. But the man in the street has pretty much the same attitude as you do about government and about politics. He is concerned with those issues with which he has direct contact and is not greatly concerned about the problems you doctors would have if we were to enact the Forand bill. To him, socialized medicine is a scare word, and he thinks maybe it would be a good thing to let the government guarantee cheaper medical care. He, too, does not always realize that if we take away freedom from the doctors and force all of you to become employees of the government, his freedom is also in danger. We have got to wake him up to the fact that a threat to the freedom of any segment of our society is a threat to the individual liberty of each one of us.

The businessman or the medical man today who remains loathe to take an active personal part in the political decisions affecting him may understand his business or his profession, but he certainly doesn't understand the free competitive system, the dangers confronting it, or his responsibility for preserving it.

I hope, by this time, I have convinced you of the necessity for you to take a more active part in politics and that you will renew your efforts to participate in politics to the end that we build up the number of representatives who believe as we do. Frankly, I am not interested in your political participation if you merely make voting a popularity contest or continue to elect sanctimonious hypocrites who talk a good job of supporting this free competitive system in which we believe, but who, on every occasion, vote to cripple and weaken it.

PROBLEMS IN CONGRESS

In the event that we are in agreement and that you are resolved to do something to save our freedom, that you have now determined to become militant crusaders to preserve our individual liberties, let me sketch just briefly the problems we face as this session of Congress gets underway and the choices we must make in this year of decision.

First, we are faced with a so-called liberal Congress—the majority of the members representing a party which essentially stands for bigger federal government, expanded welfare programs, a greater emphasis on a planned economy. In an election year it is natural that these forces will urge legislation that has a popular appeal. So look for greater pressure for legislation which will call for greater and greater spending. The President had scarcely left the Speaker's desk after delivering his State of the Union Message in which he declared that we would have a surplus of in excess of four billion dollars which he planned to apply on the national debt when leaders of the Democratic Party were presenting plans for spending it on more welfare programs.

We have the problem of split government—with a Republican, conservative administration in control of the executive branch and a Democratic, liberal Congress in charge of the law-making processes.

We still are in the midst of a cold war. Tensions are eased at the moment, but we have not eliminated the communist conspiracy which calls for final defeat of the United States and what we stand for and the ultimate world domination by the Communists. I thank God that, under President Eisenhower, we have been given these years of peace. Maybe they will prove to be the reprieve we needed to renew our own faith in our system and our own determination to save it. Now is the time we can strengthen this system and win converts to our principles of

freedom, or we can coast, take it easy, let the government take over, one by one, our individual liberties, and give added encouragement to those who would destroy all the ideals upon which we founded this nation.

In another area we saw not long ago the signing of an agreement in the steel strike. I am happy that there will be no further interruption in the production of steel, but we did not settle the issue—we merely postponed the day of reckoning. We are still in danger of a wage-price spiral and further inflation. Featherbedding practices imposed by strong, monopolistic unions threaten to price us out of the world market. There are still unions controlled by racketeers capable of paralyzing our entire economy.

As to our fiscal situation, this year of 1960, the year of decision, sees us with a national debt of some 290 billion dollars, with current bills of 90 billion and obligations due to legislation already enacted by spending Congresses of some 350 billion dollars.

Other issues slated for discussion are civil rights, more welfare programs, and taxation.

Now, what will Congress do about these problems? In every instance, we are faced with two choices, and each of these choices will either strengthen our free competitive system or lead us farther down the road to a socialist state.

We will have a new deal with huge added expenditures or we will have responsible government and a balanced budget.

In the cold war we can meet the Communist challenge by adopting their system of a regimented, planned economy with every individual working for the state and with no individual freedom, or we can strengthen our own successful free competitive system which has stood the test of time and through which we can win final victory in the cold war.

We can adopt compulsory arbitration to settle our labor problems and extend federal domination in the labor-management field which will mean that labor problems will be settled on a political basis, or we can maintain the rights of the workers and the public by bringing labor unions under antitrust law, making them responsible for their actions, and insuring us that all sides in labor disputes will play by the same rules.

We can meet our fiscal responsibilities by continuing to spend and spend and to cheapen our money by supporting an ever-increasing inflationary trend, or we can adopt sound financial programing to reduce the debt, cut expenses, and make the tax burden on our people less of a burden.

In the areas of civil rights and welfare programs we can enlarge the areas of federal control, take away more of the rights of the states, encourage the something-for-nothing idea, or we can limit government interference in the everyday lives of our citizens and allow the people to do for themselves those things which they can do best.

We have a choice to bring about greater progressivity of taxes by continuing to increase the rates as we are being urged to do by the planners, or we can encourage private enterprise and individual initiative with tax cuts and a realistic scaling down of the middle and upper brackets.

THE CHOICE

That is the choice we face in a nutshell. I could enlarge upon any of these areas, but I hope I have given you enough so that you can see the picture as it is at the beginning of this fateful year. What are you going to do about it?

Are you going to sit on your hands and arouse yourselves only when an immediate issue excites your concern? Or are you going to become militant idealists and crusaders without apology for your belief in the free competitive system and for those principles of individual liberty upon which our whole philosophy of government is based? The choice is up to you. You doctors will either help us save our system of free enterprise or you will join us as virtual slaves of the state if we go down to defeat.

♦ Mr. Alger, House of Representatives, Washington, D. C.

Federal Tax Problems of the Self-Employed

The Internal Revenue Service last year issued its regulation covering associations taxable as corporations. The Keogh-Simpson bill, H. R. 10, which would defer the tax on the income of a self-employed person so long as the money is invested in a restricted type annuity fund, is discussed.

JOHN C. WILLIAMSON
Washington, D. C.

RECENTLY the American people have been subjected to a deluge of articles deploring the inequities which run rampant through our Federal Tax Code.

In December the House Ways and Means Committee completed a month of panel discussions by professors, tax lawyers, and sundry economists who had filed 2,400 pages of comments and recommendations about what to do with our tax laws. The stage was set for radical surgery, but the doctors soon proved reluctant to touch the patient. Finally, the chairman of the House Ways and Means Committee announced that it would be 1961 before his committee would be ready to tackle the job of major tax revision.

I can well understand the hesitation with which Chairman Wilbur Mills views the monstrosity that is his patient. We have such a heavy and complex tax system that the amount of energy that goes into the legal minimizing of our tax burden is prodigious. So complex has it become that even the judges and justices of our courts must have cause to complain.

It is no exaggeration to say that we have a number of Federal Tax Codes. We have one for each of the 10 Circuit Courts of Appeals, the United States Tax Court, and the United States Court of Claims. Not one of these is bound by the decision of the other 10, and the Internal Revenue Service is not bound by any. Only the United States Supreme Court can bind the Internal Revenue Service although it has been said that the service may be influenced by the lower courts.

The purpose of the impending major tax revision bill is to broaden the tax base, thereby increasing revenues sufficiently to reduce individual and corporate rates. The tax base would be broadened by eliminating deductions, such as charitable contributions, interest on personal loans and mortgages, local and state taxes including real property taxes. Some witnesses from the academic field recommended that a home owner pay a tax on the imputed income from his home. The college professor who suggested this soon warmed to his subject when he surmised that this could lead to the taxing of the imputed value of a housewife's services.

The Congress will find the task of broadening the tax base a formidable one, because of the underlying suspicion that the reward of a lower tax rate will at most be temporary. Domination of government by mass opinion—the inevitable consequence of popular democracy—moves continually toward higher tax rates. The evidence will always be there that the national incentive and a reasonable facsimile of free private enterprise survived a 91 per cent top tax

rate. Thus, the 91 per cent rate will always be a target of the great levelers in our society.

The tax deductions and exclusions in our present tax code are, of course, attributable to the tireless effort of special groups to compensate for our highly progressive tax system—the inevitable result of the emphasis which has been placed too often on tax revision: the dollar and cents result to the pocketbook of this guy they call "the common man."

Politically it has worked, and nothing is so immutable as the ideas with which political parties succeed to public office.

ASSOCIATIONS TAXED AS CORPORATIONS

On December 23, 1959, the Internal Revenue Service issued its long awaited proposed regulation covering associations taxable as corporations. In this regulation the Internal Revenue Service places its stamp of approval on an indirect, ingenious, but tortuous procedure whereby a doctor or other professional person might be able to set up a pension plan with the same tax treatment now accorded the corporation. This in effect is the Kintner and Galt decisions written into regulation.

Now it appears that a group of doctors who form a clinic may, by adhering closely to the corporate characteristics of continuity of life and centralized management, be taxable as a corporation even though each doctor remains personally liable for all claims against the clinic. Also, the majority, if not all of the doctors, must approve the transfer of the interest of one doctor to an outsider who wants to join the clinic. Thus, the way is clear for doctors to benefit from a tax deductible pension plan.

I am sure that this regulation will meet with the approval of many members of the medical profession, and the rapid growth in the number of clinics attest to the use to which this regulation will be put.

However, good or bad, the regulation underscores the deterioration of our tax laws, for instead of correcting an inequity, the new approach aggravates the existing inequity against the self-employed person or the partners who want to adopt a business form which suits their personalities, their specialties, and their desires.

The Congress is also a participant in this unhappy trend toward the "organization man." In 1958, the Congress approved what is known in the trade as Subchapter S. Under this ingenious device partners, who are able to do business as corporations, may incorporate and elect not to be taxed as corporations. Thus, partners may set up qualified pension plans and obtain tax deductions for the contributions to such funds.

John C. Williamson, vice-chairman of the Board of Directors of the American Thrift Assembly, presented this paper at the Texas Medical Association's Conference of County Medical Society Officials, January 16, 1960, in Austin.

One might ask, why drive the partners into the corporate way of doing business? Why not provide them the same tax treatment as partners? Alas, this is too logical. The tax law still insists that a partner or a proprietor is not an employee, and, therefore, he cannot participate in a pension plan.

So we now have the new tax regulation and Subchapter S to force the entrepreneur, the general practitioner, to create and become a part of a new legal entity—(1) the corporation not taxable as a corporation (this is called hybrid or pseudo-corporation) or (2) (in the case of doctors) the unincorporated association taxable as a corporation. Well, in any event, all this has enriched the lexicon of the legal profession.

KEOGH-SIMPSON BILL

The Congress has the means for bringing some order and equity out of all this legal statutory chaos. It is the bill H. R. 10, known as the Keogh-Simpson bill. In the Senate, because of the active bipartisan support of Senator George Smathers (D., Fla.) and Senator Thruston B. Morton (R., Ky.), the bill is known as the Smathers-Morton-Keogh-Simpson bill.

I am confident that you are all aware that this bill would defer the tax on the income of a self-employed person so long as the money is invested in a restricted type annuity fund. The bill would permit a deduction up to 10 per cent of taxable income although not to exceed $2,500 in any one year. Thus, the self-employed person would be placed on a par with the corporation which is now permitted such tax deductions for pension plans.

This bill is probably the most talked about and the most misrepresented tax bill of the eighty-fifth and eighty-sixth Congresses. It has been and is the object of intense, strident, almost malignant controversy. It has been headlined in the press as a loophole-creating bonanza for wealthy lawyers and doctors. It has been called budget-busting and a bill which would create yet greater inequities.

Let us look at the record.

First, I would like to answer the bill's detractors by adopting as my own the views of this public

figure who made the following statement in a speech delivered in Chicago on October 24, 1952:

> . . . In 1942 the government made an important supplement to the Social Security Act by legislation which offered tax advantages to corporations and their employees in the establishment of pension funds. I am thoroughly in accord with the principle of this legislation. Over 16,000 pension plans have been filed under this law providing more adequate security for the employees of the corporations covered thereby. When this legislation was being considered, self-employed individuals were evidently forgotten, and yet they get old and sick just as other people. There are over 10 million workers who cannot take advantage of these tax relief provisions now offered to corporation employees—owners of small businesses, lawyers, doctors, architects, accountants, farmers, singers, artists, writers and people of every kind and description who are not regularly employed by a corporation. I think something ought to be done to help these people help themselves by allowing a reasonable tax deduction for money put aside by them for their own savings. This would encourage and assist them to provide their own funds for their old age and retirement. If I am elected, I will favor legislation along these lines.

And he was elected and is the President of the United States, Dwight D. Eisenhower.

John Stuart Mill made an appropriate and relevant comment in his book "Principles of Political Economy." He said that the principle of equality of taxation "requires that a person who has no means of providing for old age, or for those in whom he is interested, except by saving from income, should have the tax remitted on all that part of his income which is really and *bona fide* applied to that purpose."

H. R. 10, the self-employed retirement deduction bill, passed the House of Representatives almost unanimously in March, 1959. Since then it has been the subject of 4 days of public hearings by the Senate Finance Committee. The bill is now the unfinished business of this committee, which has had ample time to ponder the testimony of 32 witnesses, representing as many national trade associations of self-employed persons who testified in person, and the statements filed by more than 200 organizations.

OPPOSITION TO H. R. 10

There are three sources of opposition to the H. R. 10.

The first and least understood is the National Education Association. One would think that this lobby would have its hands full with the hardy perennial—a federal aid to education bill. Yet the NEA persists in its opposition to a bill designed to encourage self-reliance and the entrepreneurial class. Apparently, the NEA has thrown in its lot with the cult of the mass and its product, the "well-rounded organization man" of the corporation. Thus it joins the second opponent, the AFL-CIO in this drive of leveling everybody out, an idea recently deplored by *VOPROSY ECONOMIKI,* the official journal of the Soviet Institute of Economics as "petty bourgeois equalitarianism."

The witness for the AFL-CIO before the Senate Finance Committee premised his opposition on his belief that the self-employed person has so much opportunity for tax evasion that his cry for tax equality in the matter of pension plans should go unheeded.

The third objection came from the Treasury Department.

The department, completely oblivious to the President's support of the objective of H. R. 10, contends that the bill would involve a loss in revenue of $365,000,000 for the first year. This is at best an educated guess which has been ripped to shreds by Dr. Roger Murray, dean of the School of Finance at Columbia University, a nationally known expert on savings. He concluded that $75,000,000 to $100,000,000 would be the top deferment in taxes for the first year of operation. He bolstered his own scientifically determined figures by pointing to the experience of Great Britain with similar legislation where the actual loss in revenue was one-sixth of what the Royal Treasury had forecast.

Now, if the Treasury is so solicitous about loss in revenue, what about the $4,600,000,000 which was set aside by corporations during 1958 for pension plans involving a tax deferment or immediate loss in revenue of $1,800,000,000. These corporate pension plans are being approved at the rate of almost 200 per month, and each one involves loss in revenue.

The Treasury has conceded that an inequity operates against the self-employed. I contend that an admitted inequity should not be permitted to stand and that loss in revenue should be of secondary consideration. I contend that the doctor should not be forced into group practice in order to neutralize the effect of this admitted inequity.

FAVORABLE POINTS FOR H. R. 10

The logic which we have summoned to our aid in promoting this bill is not completely unassailable. The opponents of the measure are exploiting the fact that a corporation must have a nondiscriminatory pension plan covering most employees whereas H. R. 10 would permit a doctor, lawyer, or realtor to set up his own plan without regard to his employees.

This has given rise to reports that a compromise is in the works, that the Senate Finance Committee

may amend the bill to do one of these two alternatives:

1. Require the self-employed person to cover his employees as well as himself in a nondiscriminatory pension plan, or

2. Amend the tax code to bring a partner or proprietor within the definition of "employee" for the purpose of a section 401 pension plan.

Now what are our chances of getting H. R. 10 out of the Senate Finance Committee? There are 17 members of the Committee and we know, as of the moment, how each one of them would vote; and if my mathematics are correct, we are one vote short and that vote we must obtain.

We know that Senator Harry F. Byrd of Virginia, the committee chairman, is against the bill. We also know that the ranking Republican member of the committee, Senator John J. Williams of Delaware is against it. We know that Senator Russell B. Long of Louisiana is against it, and we know that Senator Albert Gore of Tennessee is against it. So, we are sure that there are four against it. We are equally sure that there are eight in favor of it. They are Senators Smathers of Florida, Herman E. Talmadge of Georgia, Vance Hartke of Indiana, J. Allen Frear of Delaware, Clinton P. Anderson of New Mexico, all Democrats; and Republican Senators John Butler of Maryland and Carl T. Curtis of Nebraska. On the doubtful side—and here is where the decision rests—there are five votes. One is Senator Robert S. Kerr of Oklahoma, one is Senator Paul Douglas of Illinois, one is Senator Frank Carlson of Kansas, another Senator Wallace T. Bennett of Utah, and the last Senator Norris Cotton of New Hampshire.

Senator Ralph Yarborough has declared himself in correspondence with constituents as being in favor of the bill. He has said that when the bill reaches the floor of the Senate he will support it.

In my opinion Senate Majority Leader Lyndon Johnson, the senior Senator from Texas, holds the key to this measure. His active support would insure its success. To date, he has not expressed himself in support or opposition to the measure.

The chairman of the Republican National Committee, Senator Morton of Kentucky, is a co-sponsor of the bill. It is difficult to comprehend that in this presidential election year the leaders of the Democratic Party would fail to appreciate the significance of a measure designed to remove an admitted inequity against 10,000,000 self-employed persons ranging from farmers and florists to doctors, realtors, plumbing contractors, and so on through the gamut of American entrepreneurial life.

I anticipate that the Treasury will suggest some modification of the bill and that in some form it will become law.

This in 1960! This is a bill that Senator Lyndon Johnson might well champion. What is he waiting for?

♦ Mr. Williamson, National Association of Real Estate Boards, 1300 Connecticut Avenue, Washington, D. C.

Hardy Drugs Stand Test of Time

With the publication of the sixteenth revision of U. S. Pharmacopeia in March, 54 drugs were included which have been printed in every issue of the book of standards since its inception in 1820.

Drugs which have withstood the rigid testing of the USP for 140 years:

Acacia
Alcohol
Aloe
Ammoniated Mercury
Ammonium Carbonate
Ammonium Chloride
Ammonium Hydroxide
Anise Oil
Antimony Potassium Tartrate
Aspidium
Belladonna Leaf
Benzoic Acid
Benzoin
Calcium Carbonate
Camphor
Castor Oil
Cinnamon Oil
Citric Acid
Clove Oil
Digitalis
Ether
Fennel Oil
Ferrous Sulfate
Glycyrrhiza
Hydrochloric Acid
Ipecac
Lavender Oil
Lemon Oil
Magnesium Carbonate
Magnesium Oxide
Magnesium Sulfate
Methyl Salicylate
Myristica Oil
Olive Oil
Opium
Orange Oil
Peppermint
Peppermint Oil
Potassium Bicarbonate
Potassium Hydroxide
Silver Nitrate
Sodium Borate
Sodium Chloride
Spermaceti
Storax
Stronger Rose Water
Sucrose
Sulfur
Tolu Balsam
Tragacanth
White Wax
Wild Cherry Bark
Zinc Oxide
Zinc Sulfate

(After Physicians Play Major Role in the World of the U. S. P., New Medical Materia 2:48-49, 1960.)

Conservative management is usually indicated even when ruptured lumbar intervertebral disk is suspected. Severity and persistence of sciatic pain are important diagnostic signs. Any objective evidence of nerve root involvement strongly supports the diagnosis of ruptured disk. Myelography, justified only when reasonable suspicion of rupture results from careful examination, usually should be performed in industrial patients. Surgery is indicated when a positive diagnosis is made in a patient with great disability.

Ruptured Intervertebral Disk in the Industrial Patient

Diagnosis, Surgical Management, and Prognosis

F. KEITH BRADFORD, M.D.
Houston, Texas

IT IS PROBABLY TRUE that management of industrial patients is more complicated in many ways than management of private patients. Certainly, industrial practice should be handled in such a way that the patient retains confidence in his physicians. It is necessary to discuss the patient's problem with him and have him fully understand why an operation is undertaken and what results can be expected. As in dealing with any patient, subjective symptoms as well as objective signs must be considered in making the diagnosis. However, symptoms can be distorted by the industrial patient who is overly anxious to impress his doctor, and only by a detailed and time-consuming session with the patient can a true perspective be obtained.

The diagnosis of ruptured disk should not be brought into the discussion with industrial patients until it is a relative certainty. When a patient is being treated for acute low back symtoms following an injury, there are often pains referred into the hips and, to some extent, into one or both lower extremities. A patient often says he is "paralyzed" when he means only that he is deterred by pain in his back from making movements. Hypesthesia of an entire limb often appears to be present in suggestible patients. In the absence of paralysis of sphincters or paralysis of any muscle groups and with normal preservation of tendon reflexes in the extremity, the hysterical nature of the sensory change is almost certainly assured. In the management of acute back sprain it is not necessary to make a diagnosis of ruptured disk until the more severe back symptoms are subsiding except in the rare patient who has compression of the entire cauda equina (rather than the usual monoradicular compression). Compression of the cauda equina produces absence of the ankle jerks and weakness of plantarflexor and dorsiflexor muscles of the toes and ankles as well as sphincter disturbances and saddle sensory changes. The condition is not obscure if it is looked for. An occasional patient may show typical unilateral sciatic pain early in the course after injury with back complaints only of secondary importance. This clinical picture is highly suggestive of ruptured lumbar intervertebral disk, but even so, verification by myelography is not desirable at this early date unless the

pain is requiring major opiates for relief and operation appears to be more conservative for this reason than continued hypodermic medication.

Too early myelography is objectionable for numerous reasons. First, it is not necessary unless neurological involvement becomes apparent. It often adds a headache problem in patients already uncomfortable with back pain and pain referred to other areas from the lower joints of the back. Myelography, performed before rupture is complete, may be negative in a patient who later develops a true rupture of the intervertebral disk. In the unwholesome atmosphere of premature myelography, undue emphasis on insignificant defects is common, often resulting in a positive diagnosis which is made in error. It can be said in summary that myelography is not considered until after conservative treatment has been continued a minimum of 3 weeks, or longer if improvement is occurring, unless definite symptoms or signs of nerve root involvement become evident. Unilateral sciatic pain which becomes worse as back symptoms improve is the usual indication for myelography. When it is due to a ruptured disk, increase in the sciatic pain by coughing or sneezing is usually a prominent symptom.

Conservative treatment of the acute low back sprain consists at first of rest in a bed with boards placed beneath the mattress and administration of medications sufficient to relieve severe pain. There is no objection to the use of hypodermic opiates for a few days when it is apparent that pain is severe. Muscle relaxants may be used. There is no objection to Buck's extension or traction with a pelvic harness, but I personally believe that simple bed rest is equally effective. At times, traction, by limiting the possible positions of the patient in bed, necessitates larger doses of analgesic medication. Bathroom privileges are allowed as soon as the patient can manage to get up without prolonged aggravation of pain. Back supports are of no great importance until the patient can be out of bed for longer periods. It is my opinion that back supports at times permit earlier return to work.

DIAGNOSIS OF RUPTURED DISK

The history of back disability is uniform in patients who later develop unilateral radicular pain in the distribution of the sciatic nerve as a result of compression of the fifth lumbar or first sacral nerve root. However, the sciatic pain, because of its severity, may so seize the patient's attention that he fails to recount his back disability, which is often of no greater severity than on numerous occasions in the past. The severity of back pain does not appreciably increase the probability of development of nerve root compression by a ruptured lumbar disk. Increase of back pain by coughing, sneezing, or straining is the rule in low back sprain and suggests rupture of the disk only when severe hip or leg pain accompanies the back pain or occurs alone. Relief of sciatic pain by lying down is the rule in patients with early ruptured disk, but in the more chronic phases the reverse may be true. Subjective sensory changes, if well localized to particular toes or to a particular part of the leg, are highly indicative of nerve root involvement. In contrast, vague numbness or weakness of "the whole leg" is often of no discernible importance in making a diagnosis.

Dr. F. Keith Bradford, a neurological surgeon, presented this paper at the combined meeting of the Texas Traumatic Surgical Society and the Texas Industrial Medical Association in San Antonio, April 19, 1959.

In the examination there can be a number of positive physical findings which are of great importance in addition to the specific neurological findings. The lumbar lordosis is often diminished or lost with tilting of the pelvis in some instances (sciatic scoliosis). This is often unaccompanied by any particular pain in the altered lumbosacral spine. Limitation of back movement is usually present, but is variable in degree. Forward bending usually aggravates the sciatic pain. Extension of the spine also exaggerates the sciatic pain, especially if accompanied by rotation toward the affected side. Firm paravertebral pressure on the side of pain over the involved intervertebral disk often will accentuate the leg pain. When minimal pressure produces a marked response, it usually must be discounted. Bilateral jugular compression with the patient standing will often accentuate the leg pain a few seconds after it is applied (positive jugular compression or Naffziger test). The Lasègue test is usually positive in the affected extremity with additional pain resulting when the foot of the raised leg is passively dorsiflexed. It is of considerable importance when, in performing the Lasègue test in the unaffected extremity, pain occurs in the affected extremity (crossed Lasègue test).

Testing muscle power is simple in a fully cooperative patient, but can be very misleading when the patient does not make a sustained muscular effort. The ability to plantarflex and dorsiflex the foot is best tested by having the patient walk on heels and toes. Dorsiflexion of the toes can be compared on

the two sides by depressing the dorsiflexed toes by pressure over the interphalangeal joints with the feet placed flat on the floor. In lumbar disk lesions weakness is rare except in the muscles below the knee.

Sensory findings can be demonstrated in the leg and foot in certain patients. Unless the changes are definite, it is unwise to let them influence one in making a diagnosis. The first sacral dermatome is large, and involvement of this root at the lumbosacral disk often produces hypesthesia of the posterolateral leg and the little toe side of the foot. The fifth lumbar dermatome is smaller, is more anterior on the leg, and usually includes the big toe. Involvement of it results from compression of the fifth lumbar nerve at the fourth lumbar disk.

Reflex changes are of great value because of their objective character. The knee jerk is occasionally diminished in rupture at the third or fourth lumbar disk, but in most cases of rupture at the lower two intervertebral disks it is normal. At times the knee jerk will appear diminished because of the difficulty the patient has in relaxing the painful extremity. The ankle jerk is diminished or absent in about three-fourths of the patients with rupture of the lumbosacral disk. It may also be diminished, but is rarely absent, in ruptures at the fourth lumbar disk.

The nerve root findings characteristic of rupture at the lower two intervertebral disks can be summarized as follows:

Fourth Lumbar Disk Rupture (fifth lumbar nerve root)

1. Weakness in dorsiflexor muscles of foot or toes.
2. Hypesthesia of lateral leg and big toe.
3. Absence or diminution of ankle jerk.

Lumbosacral Disk Rupture (first sacral nerve root)

1. Weakness in rising to ball of foot.
2. Hypesthesia of posterolateral leg and lateral foot.
3. Absence or diminution of ankle jerk.

It is true that the neurological examination can be negative for nerve root findings in many patients with ruptured lumbar disk. However, such patients often have other typical findings and a perfectly characteristic sciatic pain. There are virtually no obscure cases of ruptured disk that should not properly be suspected on a basis of careful history and physical findings. Reexamination after a waiting period of a few weeks often reveals definite additional evidence for or against the diagnosis of ruptured intervertebral disk. Myelography is justified only when reasonable suspicion results from a careful examination. When myelography is interpreted without careful correlation with the clinical examination, it often leads to unwarranted exploration. The spinal fluid should be examined by the laboratory at the time of myelography. A spinal fluid total protein elevated to 50 to 150 mg. per 100 cc. is important supporting evidence of the presence of a ruptured disk.

SURGICAL MANAGEMENT

Surgery is indicated in ruptured lumbar intervertebral disk when a positive diagnosis can be made in a patient whose disability is great. The site of the rupture is explored by reflecting the erector spinae muscles only on the affected side. The ligamentum flavum is excised and the interlaminar space is enlarged to expose the lateral margin of the dura mater opposite the affected disk. The typical positive finding is that of nucleus pulposus extruding into the spinal canal through a defect in the annulus fibrosus. In some instances the outer lamellae of the annulus fibrosus are distended over a resilient mass which has not completely ruptured through. Proper surgical management consists of complete removal of the extruded portion of the nucleus pulposus and additional removal of all loose nucleus from within the involved intervertebral disk. This is accomplished with minimal trauma to the affected nerve root and without opening the dura mater.

Patients are allowed up within a day or two. Often there is some complaint of increased numbness in the distribution of the involved nerve root. Usually, sciatic pain is completely relieved, although it is common to have some occasional reference of pain into the sciatic distribution sometime during the first postoperative week or two. Back pain is variable and rather unpredictable in the immediate postoperative period. Patients can be discharged from the hospital in 1 to 2 weeks, often depending upon the home situation. Return to work of a sedentary type frequently can be accomplished in less than 3 months, but it is wise to wait for 3 to 6 months on active workers, even when heavy manual labor is not involved.

PROGNOSIS

Although many patients operated upon for ruptured disk have returned successfully to heavy manual labor, this cannot be uniformly expected. I am not certain that inclusion of spinal fusion as part of the operation greatly improves the prospects of return to heavy manual labor. If a change of work is feasible, it should be made. Otherwise, a patient should be given careful instruction in how to lift. Some limitations in lifting, if possible, should be imposed until 1 year after operation. There will be transitory episodes of back disability in some of these patients and recurrent ruptures at the same or another site in others.

Occasional patients will have rather severe postoperative back symptoms. In many of these progressive narrowing of the interspace operated upon will occur. In about 1 per cent of patients there will be

absorption of bone from the intervertebral surfaces —so-called interspace infection. Patients with simple narrowing will recover from back pain usually in 6 to 9 months. Those occasional patients with "interspace infection" will require 9 to 12 months for recovery. There is usually no actual suppuration or fever, but prolonged bed rest is usually necessary.

No sharp schedule can be followed in returning postoperative disk patients to work. Return to light duty when the patient is ready permits much more uniform rehabilitation than when it is necessary to return the patient to unrestricted activity. It is wise to go over with the patient what his duties will be when he returns to work.

RESULTS

In my personal series of disk operations, 35 of the last 114 cases were industrial. Four of these underwent combined fusion and intervertebral disk surgery. Their average time to return to work was 9 months. Three patients were operated upon during litigation, chiefly because of positive myelography and symptoms compatible with ruptured disk but without clearly characteristic nerve root findings. None of these 3 returned to work during follow-up periods up to 1 year. Straight industrial disk operations averaged 4 months in return to regular work. Two patients included in this group who were operated upon despite negative myelography and without completely diagnostic findings underwent negative exploration. A number of patients underwent exploration at 2 levels, a factor which somewhat lengthened convalescence. One patient with a cauda equina syndrome is included although he returned to work only after a full year. The ideal case for industrial rehabilitation is a clear-cut case with positive clinical and myelographic diagnosis of rupture at a single level and with minimal back symptoms.

Recurrent back disability is a common complication in patients who have undergone intervertebral disk surgery. The back joints are not usually weakened by the surgery, but are altered by the loss of function of the nucleus pulposus. Recurrent herniation or herniation at a new level after initial cure of sciatic pain is not uncommon, and probably occurs in as high as 5 per cent of patients operated upon.

SUMMARY

There are few emergency operations for ruptured intervertebral disk. The physician should beware of making the diagnosis unless sciatic pain is greater than residual back pain. Although incomplete radiation of pain occurs, radiation throughout the sciatic distribution is the rule. Severity and persistence of sciatic pain are important in the diagnosis as well as accentuation of this pain by coughing, sneezing, or straining. Objective findings of nerve root involvement, if definite, strongly support the diagnosis of intervertebral disk rupture.

In industrial patients, operation rarely should be undertaken without both a positive clinical and a positive myelographic diagnosis.

The best surgical results will be obtained in patients with a single rupture. Diagnosis of multiple ruptures is often erroneously made in patients with degenerative disease of several disks with rupture of none. Multiple explorations should be done only under special indications, since morbidity is increased thereby.

Dr. Bradford, 435 Hermann Professional Bldg., Houston 25.

Dr. J. Peyton Barnes read this paper from the Surgical Service of St. Joseph's Hospital before the Texas Surgical Society, meeting April 4, 1959, in Austin.

J. PEYTON BARNES, M.D.
Houston, Texas

Management of an Incision Ruptured or About to Rupture

In cases in which the patient is in poor condition and the likelihood of dehiscence of an incision is great, a method of taping the abdomen may tide the situation over until the patient's clinical condition justifies the risk of secondary surgical closure.

DEHISCENCE of an incision is always a disconcerting affair. It is a dangerous and undesirable complication, to put it mildly.

Several factors may be causative, either singly or in combination. In abdominal incisions, however, prolonged and marked distention is almost invariably present and, to my way of thinking, is the most important item. This distention usually has been present for several days prior to dehiscence, and its presence plus the appearance of a large amount of straw colored or blood tinged fluid through the incision heralds the imminence of rupture.

Patients recently operated on who develop distention sometimes may be successfully treated by small bowel intubation. If this is not successful, the usual method of handling dehiscence is immediate resuture of the incision under anesthesia, using through-and-through sutures in the attempt to join the abdominal walls in a solid mass. Since the causative factor of distention is still present, further excessive intra-abdominal pressure is created, and this plus the shock of surgery, and so forth, makes this a rather risky undertaking.

In cases where the patient is in extremely poor condition, with little or no relief of the distention, and with the likelihood of dehiscence very great, two things are much to be desired: first, to prevent complete dehiscence if possible; second, if it is inevitable, then to keep the wall separation to a minimum when rupture does occur. It is in these cases, where resuture of the incision under another anesthetic creates a grave risk, that the method to be described may be considered.

PROCEDURE

Where rupture is imminent, and without any surgically placed drains or colostomy openings, the problem is not so difficult. If a draining sinus is present, it is a little more awkward, but usually can be managed.

First, all dressings are removed. Preliminary sedation is very helpful. The entire abdomen down to the pubis is shaved, then thoroughly cleaned with soap and water. The skin is thoroughly dried, and then 2 inch width strips of ordinary adhesive tape are laid directly alongside the incision, laying the first one on each side of the incision right to its edges (fig. 1a) and working outward with similar strips overlapping each successive strip. These strips are laid smoothly, evenly, taking great care to follow

the body contour exactly. As the flanks are approached, it may be necessary to make V nicks in the outer edge of one or two of the strips (fig. 1b). This layer is carried to about mid-axillary line, probably 2 to 3 inches above the bed level.

Next a series of overlapping pieces are laid at right angles to this first layer, and, where rupture has not yet occurred through the skin edges, are laid without tension, smoothly, and with their ends extending a little farther on each side than the edges of the first layer. Again, great care is taken to follow the body curves (fig. 1b and c). In some places 1 inch strips will be easier to use. No dressing whatever is placed on the abdomen, but a tiny slip of rubber or strip of vaseline gauze rolled up may be placed as a vent, and some dressing placed on top of the adhesive, never under it.

The skin thus has been converted into a solid sheet of greatly increased strength, capable of resisting much greater disruptive force than formerly.

We cannot hope to prevent the separation of the inner wall layers, but, as they continue to separate, more room is provided within the abdominal cavity, and the extra resistance provided by the outermost layer—the skin plus the tape—may be sufficient to hold this one last layer intact until the clinical situation improves. Moreover, the skin edges will separate last of all, and with this additional support they probably will pull apart only a short distance instead of sort of "blowing apart" with evisceration. Finally, if and when they do separate, there is still a solid wall of reasonably sterile adhesive tape to prevent intestinal loops from popping out of the opening.

If rupture does occur under these circumstances, there is no shock to the patient. Separation of the deeper layers has already been occurring, and at the moment of skin separation there is little shock unless evisceration occurs. Usually the shock comes when a secondary closure is attempted.

Where rupture has just occurred, the following method is used. If a loop of bowel or other viscus is present in the incision or protruding through it, this loop is thoroughly cleaned with water and some suitable antiseptic and replaced either within the abdomen or just down to the bottom of the incision and covered with a single strip of vaseline gauze. Then the entire abdomen is prepared as outlined previously, and the first layer of tape applied. As the second layer is applied, efforts are made gently to pull the skin edges as close together as possible, with care taken to have the tension up and down the edges as nearly uniform as possible. This maneuver tends to roll the skin edges inward to a certain extent, but this cannot be helped.

In both cases, either before or after rupture, the incision is treated the same from now on. Every 48 hours the same procedure is followed: the shaving, thorough clean-up of the entire abdomen, and reapplication of the tape. In the case of rupture the vaseline gauze strip placed over the presenting loop or loops usually can be removed at the next dressing since it is an excellent creator of granulation tissue which firmly fixes the loop in the bottom of the incision.

Where a draining sinus is present, one must allow for its drainage, and also convert the wall of adhesive tape into a waterproof shed so that its adhesive qualities will not be affected and also so that the drainage will not contaminate the wound. I accomplish this by spraying the entire adhesive tape wall with a clear

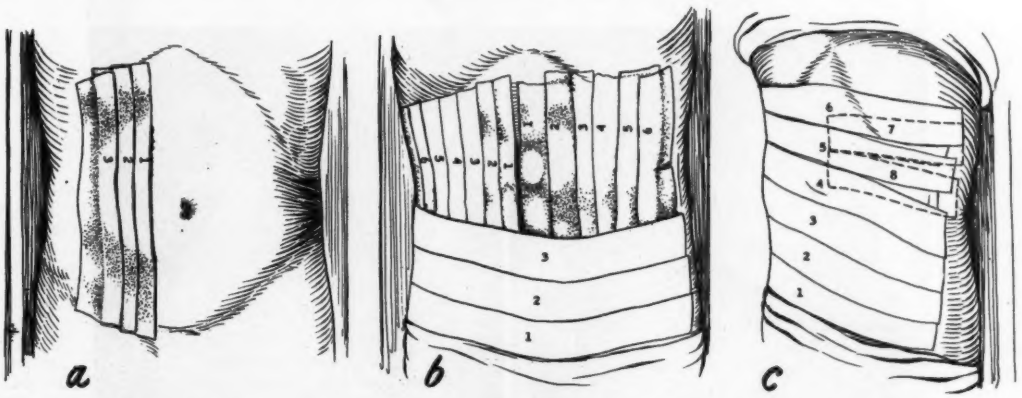


Fig. 1. Method of taping the abdomen to lessen incisional rupture.

a. The first three strips have been placed. The first is placed along the incision edge, and the others then overlap each other.

b. The first layer of tape complete, and the second layer at right angles begun. Note the small V nick in the edge of one strip of the first layer to make it follow body contour. Note also that the ends of the second layer extend about an inch over the outer edge of the first layer on each side.

c. Entire application completed. A few extra pieces of tape may have to be placed as shown by the broken lines.

acrylic plastic spray. The one marketed as "Plasti-Kote" seemed the best of those I tried. It dries in about one minute, after which a second layer is sprayed on. This has been adequate in duodenal fistulas.

Several questions are pertinent: 1. How long can this substitute for an intact abdominal wall be used? 2. How long will the skin stand the use of the tape?

CASE REPORTS

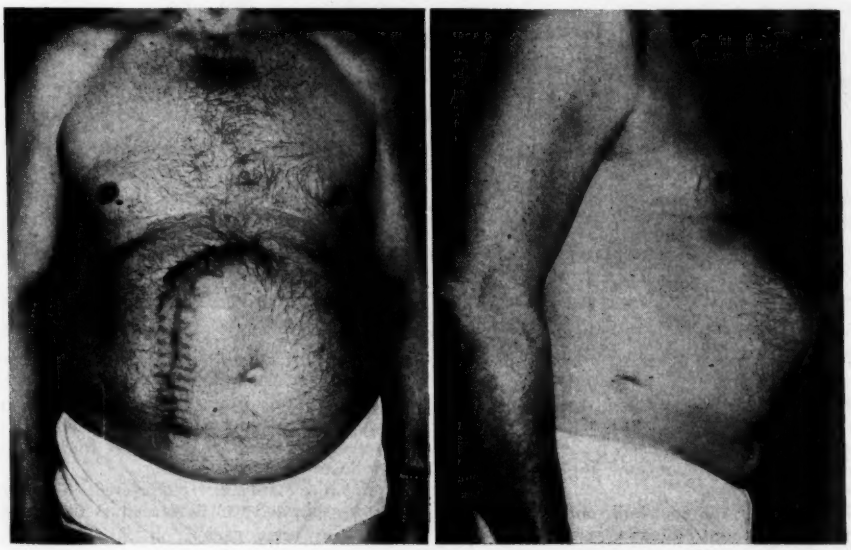
Two case reports are submitted herewith.

CASE 1.—Mr. W., a heavy drinker, aged 56 years, was admitted to the hospital with a large epigastric mass. This was a huge pancreatic cyst, considered by the pathologist, Dr. P. M. Marcuse, as the end result of acute hemorrhagic pancreatitis. This was entered through a rather long right rectus incision, cleaned out, and drained, using suction for several days to the bottom of the cavity. The peritoneum was closed with interrupted 0 chromic sutures, the anterior rectus fascia with stainless steel wire 000, interrupted. There was a profuse drainage postoperatively, with considerable abdominal distention, but the distention did not seem to approach the critical point. About 4 days postoperative the incision simply disintegrated from one end to the other. Since it had come apart as if by chemical dissolution rather than mechanical factors, it seemed futile to expect that resuturing would be of any avail. The patient therefore was treated as described for 17 days, and at the end of this time his abdomen was flat, soft, and the condition markedly improved. Under anesthesia the distal two-thirds of the entire incision was again closed, with only the skin of the proximal one-third being closed as drainage was still present. The patient has made a good recovery, but of course has a bulging hernia in the upper section of the incision (fig. 2).

CASE 2.—Mr. E. P., a white man, aged 67 years, rather emaciated looking, was admitted to the hospital for removal of a small anal mass. This proved to be squamous cell carcinoma on October 3, 1958, the day after admission. An abdominoperineal resection was decided on and performed on October 8. This patient failed to do well from the start. The colostomy did not work properly, or as soon as it should. Some distention was evident right after the first postoperative day. However, he got along reasonably well, and the sutures were removed on the eighth day. By the twelfth postoperative day he was vomiting, and distention was marked. A roentgenogram showed small bowel obstruction. On October 20, the abdomen was explored, a tight band obstructing the small bowel released, and the bowel decompressed. After this a Cantor tube was started down, and by October 25 it was making its way along the jejunum, but some distention was still present. His condition was rather poor. On October 26 some serous fluid was making its way through the incision, and rupture appeared likely. Therefore, on this date his abdomen was taped as described, except that allowance had to be made for the colostomy opening, and a different way of applying the tape was used in order to follow his body curves. His incision was then retaped every other day from then, and on October 29 the skin and anterior rectus sheath were separated from end to end except for about 2 inches of skin still intact at the upper end. The peritoneum and posterior fascia did not separate. On November 3, about 7 days after separation, we began taking photographs of each dressing (fig. 3). On November 18, about 3 weeks after the separation, secondary closure under general anesthesia was done, closing the anterior fascia and skin. The fascia held, but the skin did not. The adhesive dressing was continued as shown, and when the patient went home on December 9 the fascia was still intact but the skin had not quite healed over.

On October 29 I used the plastic spray for the first time. Two applications were used each time. This formed a waterproof shed of the adhesive wall that was easy for the

Fig. 2. Case 1. A patient with pancreatic drainage shown standing, front and side views.



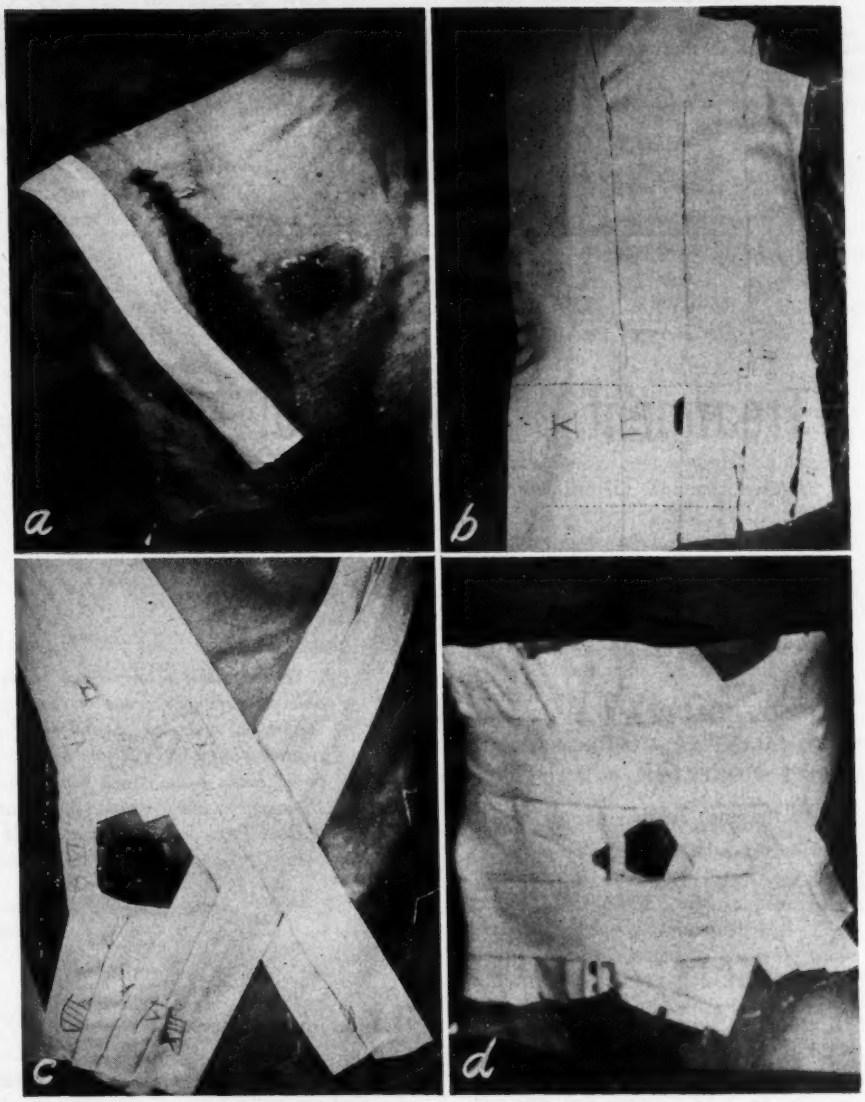


Fig. 3. Case 2. Some of the steps in taping a patient with colostomy from abdominoperineal resection.

a. Application of the first strip of tape at the edge of the incision.

b. and **c.** Successive steps in placing the first layer of tape.

d. The first layer completed and the second begun.

nurses to clean, and it prevented contamination and I believe helped the adhesive to remain stuck as it had been placed. The items of unusual interest here are these: The incision, except for the peritoneum and posterior fascia, separated on October 26, and on November 3 (8 days later) the patient was able to get out of bed and start getting around with no other support than this adhesive wall. He continued to be up and around every day then until the secondary closure on November 18, or 23 days after separation.

SUMMARY

A method for managing an incision on the verge of, or over the brink of rupture in desperately ill patients has been presented.

It has been shown that complicated cases such as those with pancreatic juice drainage and colostomies present can be handled fairly well and the patient

tided over till his clinical condition justifies the risk of secondary closure.

It is of course strictly a makeshift procedure, but in the words of the British soldier in World War I, whose fox-hole companion was complaining about the shelling they were enduring, "If you know a better 'ole, 'op to it."

♦ Dr. Barnes, 617 Medical Towers, Houston 25.

Treatment of Superficial Mycoses With Griseofulvin

J. FRED MULLINS, M.D.,
NOEL A. JAMPOLSKY, M.D., and
MARY E. PINKERTON, M.D.
Galveston, Texas

Griseofulvin administered orally is a valuable therapeutic agent in management of superficial mycoses. A total of 77 cases with clinical diagnoses of tinea capitis, tinea corporis, tinea pedis, tinea manuum, and onychomycosis and diagnostic cultures is reported. Toxic reactions were mild and temporary.

GRISEOFULVIN, which is a product of Penicillium griseofulvum and other species of Penicillium, was first isolated in 1939 by Oxford, Raistrick, and Simonart.[5] In 1958, Gentles first reported the successful use of oral griseofulvin for experimental Trichophyton and Microsporum infections of guinea pigs.[2] Early reports by Williams and others,[7] Blank and Roth,[1] Mullins and others,[4] and Kirk and Ajello[3] have shown that orally administered griseofulvin is an effective means of therapy for many superficial mycoses.

The purpose of this paper is to present further observations on the use of this medication with particular reference to dosage schedule, effectiveness, toxicity, and recurrence rate.

Material (Grifulvin) in the study was supplied by McNeil Laboratories, Inc., a subsidiary of Johnson & Johnson.

Method and Materials

A preliminary report was published on the earlier observations of 24 patients attending the Dermatology Clinic of the John Sealy Hospital. We now have a total of 77 cases, representing all age groups. Forty-one are males and 36 are females. The clinical classification and the cultural diagnoses are summarized in table 1.

All patients were diagnosed prior to therapy through cultural examinations using Littman oxgall agar on petri plates as the original isolation medium, as well as with microscopic examinations of preparations cleared in 10 per cent potassium hydroxide. A base line of complete blood counts, urinalyses, liver function tests, and photographs were taken. During therapy, whenever possible, patients were seen at weekly intervals at which time potassium hydroxide

studies, cultures, complete blood counts, Wood's light examinations, and clinical evaluations were done. Liver function tests, urinalyses, and photographs were repeated at completion of therapy. The patients were then followed at weekly, biweekly, and monthly intervals, each time with cultures, in an attempt to determine reinfection rates.

TABLE 1.—*Diagnosis and Organism.*

Clinical Diagnosis	Organism	No. Patients Male	Female	Total
Tinea capitis	T. tonsurans	4	4	8
	M. audouini	3	1	4
	M. canis	2	1	3
				15
Localized tinea corporis	T. rubrum	13	14	27
	T. mentagrophytes		1	1
				28
Tinea pedis	T. mentagrophytes		1	1
	E. floccosum	1		1
	T. rubrum	1		1
				3
Tinea manuum	T. rubrum	1		1
	T. mentagrophytes		1	1
				2
Generalized tinea corporis	T. rubrum	7	7	14
	E. floccosum		1	1
	T. tonsurans		1	1
				16
Onychomycosis (alone)	Negative culture	1		1
	T. rubrum	1	1	2
Onychomycosis (with tinea corporis)	T. mentagrophytes		1	1
	T. rubrum	7	2	9
				13
Total patients				77

Griseofulvin was administered orally at a dosage of 1 Gm. per day in adults and 14 mg. per kilogram of body weight per day in children. This dosage was reduced in order to determine minimal effective dosage, and later increased if the patient failed to show a satisfactory clinical response. Therapy was continued until there were either two consecutive weekly negative cultures or a clinical cure.

Discussion of Results

The results of our observations are summarized in tables 2 to 5. Of the 15 patients with tinea capitis, 13 have been discharged as cured. They have shown no evidence of reinfection by cultural examinations, Wood's light, or clinical appearance during follow-up periods ranging from 1 to 6 months. There was cessation of pruritus within the first week in the patients in which this was a prominent symptom. No definite change in the hairs could be observed until the second or third week, at which time, Wood's light examinations revealed a 1 to 2 mm. nonfluorescent zone at the proximal portion of fluorescent hairs. Potassium hydroxide examinations of these hairs showed a relatively sharp line of demarcation between normal healthy hair and infected hair. As therapy was continued, this nonfluorescent zone would grow until eventually the fluorescent tip could no longer be observed. In 1 patient, this phenomenon of a fluorescent tip persisted until the fifteenth week, although repeated cultures were negative from the fourth week. Potassium hydroxide examinations of an infected hair of this patient revealed mycelial elements without spores within the shaft near the tip. This corresponded to the fluorescent zone seen with Wood's light.

An unusual observation, seen in several patients, has been a fluorescent zone at the base of some of the newly formed hairs. Repeated potassium hydroxide and cultural examinations of these hairs have been negative. This has been proposed as a false positive fluorescent keratin ring at the junction of the hair and scalp.[6]

Two of our patients with tinea capitis failed to respond. In 1 patient it was because of inadequate therapy over too short a period of time. The other patient was a 6 year old child admitted to the hospital for malignant reticulo-endotheliosis. At the time of admission, he also had a localized area of tinea capitis from which Microsporum canis was cultured. An initial dosage of griseofulvin at 125 mg. every third day was instituted. Because of this low dosage it was decided to combine this therapy with topical application of U.S.P. Whitfield's ointment and daily Phisohex shampoos. Within 3 weeks, M. canis had spread to involve the majority of his scalp and approximately 90 per cent of his body surface. Over the next 10 weeks he received a total of 10 Gm. of griseofulvin. No toxicity was noted; and at the time of discharge from the hospital, his body lesions had cleared, but his scalp remained involved. Nine weeks later he died, still infected. Autopsy was refused.

During therapy, 2 of our patients with tinea capitis developed pustules at the site of infection, but in no patient did a classical kerion celsi develop. Because of the few patients with tinea capitis that we have seen, we are unable to arrive at a definite conclusion as to minimal optimal dosage or treatment time. We are of the opinion that neither the potassium hydroxide examination nor the Wood's light, if used alone, are reliable methods for determining when to stop therapy, and repeated cultures

TABLE 2.—*Results of Therapy: Tinea Capitis.*

Organism	Total Dosage (Gm.)	Duration of Therapy (Wk.)	No.	Cleared	Recurred	Failure
T. tonsurans	13-21	3-7	7	7	0	0
	3.7	3	1			1*
M. audouini	4.5-15	5-15	4	4	0	0
M. canis	10-30	6-10	2	2	0	0
	10	10	1			1†
Total			15	13	0	2

*Died of gunshot wound, and at time of death no improvement had been noted.
†Patient in hospital on steroids for malignant reticuloendotheliosis.

TABLE 3.—*Results of Therapy: Localized Tinea Corporis.*

Organism	Total Dosage (Gm.)	Duration of Treatment (Wk.)	No. Treated or Retreated	Cleared	Recurred	Weeks to Recur	Lost to Series	Failure
T. rubrum	>21	3-12	17	17	1	3	3	
	<21	1-12	17	16	9	3-15	2	*
T. mentagrophytes	19	3	1	0	0	0	0	†
T. pedis all types	>21	3-7	3	2	0	0	0	†
T. manuum all types	20-49	3-7	3	2	1	1‡		

*Had loss of libido after 7 days and patient did not return for follow-up.
†Not yet clear and is under treatment.
‡Recurrence in 1 week after discontinuance of therapy after 5 negative cultures and 49 Gm.

TABLE 4.—*Results of Therapy: Generalized Tinea Corporis.*

Organism	Case	Dose (Gm.)	Cleared	Recurred	Weeks	Failure	Comment
T. rubrum	1	28	x	x	2		
	2	35	x	x	2		
	3	28	x	x	1		
		28	x				
	4	35	x	x	12		
		28				x	Did not return
	5	55				x	No relief of pruritus
	6	14				x	No relief of pruritus
	7	49	x				
	8	33	x				
	9	63	x				
	10	21	x				
	11	35	x				
	12	41	x				
	13	25	x				
	14	35	x	x		x	*
E. flocossum	15	35	x				
T. tonsurans	16	60	x	x	8		Pregnant†
Total	16	18	15	5		4	

*Had cleared clinically but on return visits both T. rubrum and T. mentagrophytes were cultured. Then condition recurred clinically.
†Cleared. Eight weeks later returned with T. rubrum on arms only.

TABLE 5.—*Results of Therapy: Onychomycosis.*

Organism	Case	Dose	Regrowth of Nails to Date (%)	Skin Involvement	Results of Skin Involved
T. rubrum	17	1 Gm./d. x 42 d. 2 Gm./d. x 105 d.	75	None	
	18	1 Gm./d. x 36 d.	75	None	
	19	1 Gm./d. x 120 d.	60 finger nails 30 toe nails	T. corporis	Clear
	20	121 Gm. in 180 d.	90	T. manuum	Clear in 6 mos.
	21	1 Gm./d. x 105 d.	100	Gen. T. corporis	Clear
	22	1 Gm. q.i.d. x 20 d.; 1 Gm./d. x 120 d.	80 (2 nails complete)	T. corporis	Clear
	23	1 Gm./d. x 49 d.	50	T. cruris	Clear
	24	1 Gm. q. 3 d. x 210 d.	80	T. manuum	Clear in 7 wk.
	25	1 Gm./d. x. 75 d.	10	T. pedis	Clear in 6 wk.
	26	1 Gm. q. 3 d. x 49 d.	10	T. cruris	Clear in 5 wk.
	27	1 Gm./d. x 38 d.; 1 Gm./d. x 75 d. on steroids	80	Gen. & deep pustular	Clear in 5 wk. Recurred in 3 mo. Clear at 8 wk.
T. mentagrophytes, toe nails	28	1 Gm./d. x 105 d.	75	None	
None	29	1 Gm./d. x 32 d.; 2 Gm./d. x 65 d.	No change*	None	

*Culture positive in 1949-1951 and negative since.

are thus necessary. The hairs in the involved area should be clipped very close to the scalp following 3 weeks of therapy.

Practically all of our patients with tinea corporis, regardless of severity, duration or previous therapy had cessation of pruritus within 3 to 5 days. Cultures from glabrous skin would remain positive from 1 to 4 weeks, and often the potassium hydroxide test would remain positive for an additional week. Since we used as our criterion for stopping therapy either two consecutive negative cultures or clinical clearing, many of our patients with localized varieties of tinea corporis such as tinea cruris would be clear on less than 21 Gm. We believe that it is significant that of the 17 patients who were treated with less than 21 Gm., there were 9 patients who developed clinical and cultural reactivation of the disease, while of the 17 patients treated with 21 Gm. or over, there was only 1 patient who had further difficulty, and this patient had received 22 Gm.

One patient with tinea manuum due to Trichophyton mentagrophytes became clinically negative after 49 Gm. of griseofulvin. Also four weekly cultures were negative before griseofulvin was discontinued. One week later a positive culture was obtained, and over the next several weeks a clinical reinfection occurred. An additional 21 Gm. was given, and again the patient cleared. During this second course of therapy, it was found that the patient's pet rabbit was infected with T. mentagrophytes, and upon removal of this source of reinfection, she cleared. This patient illustrated the necessity of removal of all reservoirs for reinfection.

The majority of our patients with generalized tinea corporis were cleared on griseofulvin therapy. Almost all of these patients had their disease for many years and had not responded to any previous therapeutic agent. The amount of griseofulvin required to clear our patients varied from 21 to 63 Gm. There were 4 patients who cleared and subsequently relapsed, and 3 failures. One failure (case 4) was in a patient who received 28 Gm. to treat a recurrence and was then lost to our series.

One patient (case 5), while on steroids, received a total of 55 Gm., yet her disease was not affected in any discernible manner other than a slight decrease in pruritus. Griseofulvin was then discontinued and 3 months later reinstituted. During this second course of therapy a topical fungicide which previously had not helped her was added by the patient to her routine. After 28 Gm. over the next 4 weeks she finally cleared completely.

One patient (case 27) had a generalized deep pustular eruption as well as onychomycosis. With the exception of her nails she became clinically and culturally clear after receiving 38 Gm. Griseofulvin was discontinued and her nails continued to grow out for the next 6 weeks and even had several negative cultures. A short time later a clinical and cultural recurrence appeared on her glabrous skin.

Because of this patient and of our earlier experience with recurrences, it was decided to treat all pa-

tients with onychomycosis, regardless of cultural or skin involvement, until they were completely clinically clear. In the 11 other patients we treated in this manner with dosages up to 300 Gm. over periods ranging to 8 months, there has been no recurrence on the glabrous skin. There was, however, only 1 patient whose nails cleared completely. Others had several of the nails cured with certain nails being slower to respond. Usually the thumb nail and then toe nails are the last to show response. Nails heal slowly by the mechanical extrusion of infected nail by normal nail.

One patient (case 29) a physician, presented dystrophic changes in all the nails of the hands and feet. He gave a history of positive cultures of Trichophyton rubrum obtained in 1949, 1950, and 1951. Although the potassium hydroxide study was negative, therapy with griseofulvin was started, and after 4 months, it was stopped. We had attempted repeatedly to obtain a positive culture, yet all our results were negative. After 4 months of therapy his dystrophic nails showed no response to treatment. Because of the long course of therapy necessary for onychomycosis, this patient very dramatically emphasized the necessity of obtaining a positive culture before starting griseofulvin.

Since our routine isolation medium was Littman oxgall agar, an interesting laboratory feature was noticed. In the vast majority of cultures done as follow-ups on patients who had been treated with griseofulvin, Pityrosporum ovale was the only isolate. In many instances, our culture plates were filled with this organism. We believe this observation will warrant further investigation.

Side Effects and Toxicity

In no patient have we been able to detect any significant changes in hemoglobin level, liver function test, or urinalysis. In our earlier investigations, we had 3 patients develop a temporary mild granulocytopenia. Subsequent to this we have had no patient develop a significant change in his white blood count. Several patients developed bacterial infections during griseofulvin therapy and showed a normal granulocyte response.

Three patients developed headaches, but all voluntarily continued therapy. Two patients had nausea and vomiting with the first few tablets. One patient developed a generalized pruritus with no visible lesions. His pruritus disappeared within 24 hours after discontinuance of griseofulvin. Two patients developed a papular urticaria near the completion of their therapy, and 1 patient developed a papular erythematous eruption on the seventh day which disappeared in the face of continued therapy.

One patient (case 17) had a generalized morbilliform eruption which cleared when therapy was discontinued. Several weeks later griseofulvin was reinstituted, and he developed erythema multiforme. This, too, cleared after stopping the drug. Griseofulvin was once again reinstituted, and the patient has now received a total of 121 Gm. for his onychomycosis with no further reactions.

Dr. J. Fred Mullins and his coauthors submit this paper from the Department of Dermatology (Dr. Mullins, chairman), University of Texas Medical Branch.

One patient (case 27) developed a hypertensive episode. This patient had similar attacks prior to therapy and had no further attacks when griseofulvin was once again administered. One patient complained of loss of libido at 4 weeks of therapy; however, this symptom was temporary.

In no patient in whom there was a history of previous penicillin sensitivity was there a reaction to griseofulvin.

Summary and Conclusions

Oral griseofulvin is a valuable therapeutic agent in the management of superficial mycoses. It often will be effective for patients in whom all other forms of therapy have failed.

All patients should have positive cultures prior to the institution of therapy.

Toxic reactions were mild and temporary. They included headaches, temporary eruptions, nausea, vomiting, and pruritus. Until further evaluation of this drug has been done, it may be wise to repeat peripheral blood counts and differentials during a course of therapy.

Both infected hairs and nails heal by mechanical replacement with normal components.

Patients with tinea capitis should be followed until two negative cultures are obtained. False positive potassium hydroxide studies and Wood's light examinations may be found.

In order to keep recurrence rate at a minimum, patients with localized tinea corporis should receive a minimum of 21 Gm. and then be followed like

generalized tinea corporis until two consecutive cultures taken at weekly intervals are negative or until there is complete clinical clearing.

An optimal therapeutic dosage for onychomycosis is yet to be determined.

REFERENCES

1. Blank, H., and Roth, F. J., Jr.: Treatment of Dermatomycoses with Orally Administered Griseofulvin, A.M.A. Arch. Dermat. 79:259-266 (March) 1959.
2. Gentles, J. C.: Experimental Ringworm in Guinea Pigs; Oral Treatment with Griseofulvin, *Nature* (London) 182:476-477 (Aug.) 1958.
3. Kirk, J., and Ajello, L.: Use of Griseofulvin in Therapy of Tinea Capitis in Children, A.M.A. Arch. Dermat. 80:259-267 (Sept.) 1959.
4. Mullins, J. F.; Jampolsky, N. A.; and Pinkerton, M. E.: Oral Treatment of Superficial Mycoses with Griseofulvin, Texas Rep. Biol. & Med. 17:411-422, 1959.
5. Oxford, A. E.; Raistrick, H.; and Simonart, P.: Studies in Biochemistry of Micro-organisms; Griseofulvin, $C_{17}H_{17}O_6Cl$, Metabolic Product of *Penicillium griseofulvum* Dierck, Biochem. J. (London) 33:240-248, 1939.
6. Pipkin, J. L.: Personal communication.
7. Williams, D. I.: Marten, R. H.; and Sarkany, I.: Oral Treatment of Ringworm with Griseofulvin, Lancet 2:1212-1213 (Dec. 6) 1958.

♦ Drs. Mullins, Jampolsky, and Pinkerton, Department of Dermatology, University of Texas Medical Branch, Galveston.

Fewer Attracted to Medicine May Cause Doctor Shortage

What has happened to the lure of the medical profession as a career in the minds of the young?

A recent article in the *San Jacinto Times* at Coldspring points out the drawbacks of former lures and lists the newer problems which have cropped up.

Besides the competition of other sciences, the length and expense of the medical course in an inflated economy, and the fact that a large percentage of students are married, fewer students are available because of the reduced birthrates of the depression years.

Modern developments in medical practice have tended to promote less friendliness, resulting in a less friendly public attitude. This has become another drawback. The author of the article has advocated improvement of attitudes by deed, example, and intent by the student, the adults who guide him, and the professional educator and medical practitioner.

Another drawback is an impression left by doctors and educators that the medical profession entails too much hard work, involves problems of tax, litigation, and eventual socialization. In addition, an impression has been left that many other careers give as much satisfaction without sending the individual through the "hell" it takes to become a doctor.

"What hell?" asks the author, "What's the matter with us? Is there anything in the world more exciting than the study of how we behave like human beings?

"Is there any experience more exhilarating than the capacity to think logically, physiologically, and psychologically? Is there anything more thrilling than the dignity the physician in our society possesses based upon the fact that people instinctively trust a physician with their confidence, their hopes, their lives?

"Is there anything more wholesomely humbling than to live in the presence of scientific advances which can bring comfort and relief to human beings in pain and suffering if we administer wisely and well? Anything more wholesomely humbling than to keep in touch with the edge of the known where it seems to touch the unknowable, some segment of which may become tomorrow?"

The author declared that we must return to the avenues of emphasizing the positive in medicine, the opportunity to serve, achieve, and contribute without regard to the hardship, the complications, and the criticisms. Then we may halt the doctor shortage and protect the national health.

Present Status of Diagnostic Biliary Drainage; Its Indications

Diagnostic biliary drainage, one method of studying the duodenobiliary zones, is described. Its use by clinics and gastroenterologists depends on an experienced knowledge of the procedure, a capably trained technician, and the ability to interpret biliary drainage findings.

AUGUSTUS A. HALL, M.D.
SAN ANTONIO, TEXAS

DIAGNOSTIC BILIARY drainage, a procedure proposed by S. J. Meltzer[9] and developed clinically by B. B. Vincent Lyon, has been one method of studying the duodenobiliary zones since its introduction by Dr. Lyon in 1919.[7] Diagnostic biliary drainage is a selective method of examination. Its use by various clinics and gastroenterologists depends on an experienced knowledge of the procedure, a capably trained technician, and the ability to interpret biliary drainage findings.

Listed in this paper are some of the indications for diagnostic biliary drainage which are supported by others in this field.

Survey Type Examination

There is a group of patients who have had vague gastrointestinal complaints over a period of years. Most of these patients are not bedridden, but are able to perform useful work. Many of them have been classified as neurotics, constitutionally inadequate personalities, or perhaps neurasthenics. They have received, at various times, laxatives, barbiturates, "liver pills," or antacids.

Such patients should have the survey type examination.[2] This should include a thorough and painstaking history, a general physical examination, a roentgen study of the gastrointestinal tract, a fractional gastric analysis, diagnostic biliary drainage, proctosigmoidoscopy, and any other laboratory tests indicated. One can feel more comfortable in classifying the patient as neurotic or psychosomatic after the completion of this study. The diagnostic biliary drainage should be a part of this survey. Sometimes the earliest stages of bile tract disease, such as cholangitis or bile tract stasis or an infestation may provide the answer to the case in question.

Cholelithiasis

The presence of excess calcium bilirubinate and cholesterin crystals in bile sediment is pathognomonic for formed or for forming gallstones in about 90 per cent. Bockus in 1928[12] in a series of 46 operatively proven cases of cholelithiasis found this combination in 55 per cent and combined or single in 74 per cent of the cases. Mateer reported, in 1956, a series of 57 proven gallstone cases where the combination was

present in 39 per cent and one or the other in 67 per cent of his cases. This has been supported by other workers.

According to Machella[8] the following circumstances should demand a diagnostic biliary drainage:

a. A positive clinical history and normal cholecystogram. The stone shadows may be hidden by the density of the dye.

b. A nonfunctioning gallbladder, as revealed by the cholecystogram, with no evidence of calculi and absence of a typical history of a cholelithiasis.

c. Cholesterosis or "strawberry" gallbladder.

d. Common duct stasis as a result of stone, stricture, tumor, or adhesions.

In a series of 1,500 biliary drainages performed by me, 32 were in patients diagnosed positively as cholelithiasis. The average amount of B or gallbladder bile recovered was 63 cc. ranging from 10 to 130 cc. In 4 of the 32 patients, the pathognomonic combination of cholesterin and calcium bilirubinate crystals were seen.

Dr. Augustus A. Hall presented this paper before the Texas Society of Gastroenterologists and Proctologists, April 19, 1959, in San Antonio.

Postcholecystectomy

Six to 10 weeks following cholecystectomy, diagnostic biliary drainage should be performed to ascertain if there are any "left-overs" of disease. Remaining duct stones may be detected by finding the pathognomonic crystals in the bile sediment. A cholangitis also may be detected. It is especially valuable in those with jaundice in whom roentgenographic study is precluded.

In bile duct stricture, aspirated duodenal contents may be largely free of bile indicating that there is more or less complete obstruction to the entry of bile into the duodenum. If bile stained material is obtained, the existence of complicating cholangitis may be suggested by the presence in the duodenal aspirate of large amounts of cellular debris, shed epithelial cells, bile stained bacterial colonies, and leukocytes.

In some patients, a few days after cholecystectomy the sphincter of Oddi becomes spastic and dilatation of the common bile duct occurs. With prolonged spasticity of the sphincter, stasis may develop. Regurgitation of bile also may occur into the pancreatic duct in the presence of a common channel. The liver and pancreas are endangered more by the type of dyskesia following cholecystectomy than other types, chiefly because the compensatory function of the gallbladder is lacking. Livers subjected to this form of stasis occasionally have bile as dark and viscous as gallbladder bile. White bile also is often seen in this type of case.

In 1941, I reviewed a series of 57 biliary tract cases of my own,[1] each of which received both cholecystographic study and diagnostic biliary drainage. Of the 57 cases, 26 were not visualized by radiography. In these 26 cases, the results of the biliary drainage study showed the following: The average amount of gallbladder bile obtained was 53 cc.; oleaginous degeneration 1+. Gallstone crystals were found in 7 of the 26 cases. Seven of the 57 cases were the slow emptying type. The average amount of B bile in these 7 cases was 102 cc. Five of the 57 cases were roentgenographically positive for gallstones. Confirmatory evidence was found by biliary drainage in all 7 cases.

Cholesterosis

Diagnostic biliary drainage detects the cholesterin crystals in about 75 per cent of proven cases. In 1957, Mitty and Rousselot[10] reported a series of 38 proven cases of cholesterosis in which a preoperative diagnosis was correctly made in 21 of them using diagnostic biliary drainage.

Jaundice

Where jaundice is thought to be due to obstruction, the study of the bile may reveal the typical crystals suggestive of stone. Parasites may be recovered and sometimes explain the jaundice. The typical pathologic entities of acute cholangitis may be found and, thus, explain the jaundice. An excessively spastic sphincter of Oddi can be detected by duodenal drainage. This may be a contributing factor.

Diagnostic biliary drainage is especially helpful in the differential diagnosis of jaundice when the clinical and roentgen findings are indeterminate. Tumen recently emphasized that in doubtful cases of jaundice, the introduction of a tube into the duodenum is often a worth-while procedure. If even a few cubic centimeters of bile drain through the tube, this will serve to exclude complete biliary obstruction.

Parasites

Although an increased eosinophil count is not dependable in many cases of infestation, when an increased count occurs in a vague case, a diagnostic biliary drainage is indicated. The common types of parasites that infest the duodenum and biliary tract are Giardia lamblia, Strongyloides stercoralis, Endamoeba histolytica, Chilomastix mesnili, and Ascaris lumbricoides. In Strongyloides stercoralis infestation, the symptoms may be more severe than formerly described in texts. Patients can have diarrhea, abdominal pain with tenderness, jaundice, symptoms of acute gallbladder, or vomiting. Some cases present a vague picture. Kyle reported a fatal case.[6] The filariform larvae were found in the usual locations and, in addition, were found in the myocardium, lungs, trachea, liver, and gallbladder.

Cholecystitis

Diagnostic biliary drainage helps to classify the various types of cholecystitis so that the truly surgical varieties may be separated from the catarrhal types. It can detect those few cases of cystic duct obstruction due to catarrh.

In acute cholecystitis, diagnostic drainage should never be used until the acute condition has subsided in those cases the surgeon has elected to observe instead of doing an operation at once. In acute and subacute cholecystitis there is usually an increase in bile stained flocculi. On microscopic examination, there will be seen excess gallbladder epithelial cells, excess mucus combined with granular bile salts, and excess numbers of leukocytes. Usually, very dark viscid black-brown B or gallbladder bile is more apt to be recovered in noncalculous cholecystitis. Lighter colored gallbladder bile is found in gallbladders containing stones. In a large percentage of chronic cholelithiasis cases, crystals will be seen.

In early cholecystitis with an unobstructed duct, gross and microscopic evidence in the drained gallbladder bile may be obtained. There are alterations in the composition of the bile. It becomes more viscid and contains increased numbers of flocculi microscopically showing the products of catarrh and inflammation, mucus, pus cells, desquamated epithelial cells, and perhaps an occasional bile-stained bacterial colony.

In cases of early cholecystitis with obstructed duct due to organized mucus, this method of examination is of great importance. An examination of the biliary drainage fluid will show no B bile or in small amounts. Yellow to greenish mucus flocculi in shaggy, slimy masses are seen on the slide. The mucus is dense. Microscopically, it is seen as twisted or spiraled and is encrusted with bile salts of a granular character. Bright yellow oily oleaginous degenerative material can be seen melting out of the material on the slide. After several drainages, the thick gallbladder contents may, and usually do, evacuate, and many of these cases will be reported as normal on subsequent cholecystographic studies.

Such evidence assumes importance in the presence of a doubtful history, a debatable cholecystogram, or a negative physical examination. Only positive findings are of importance, except the recovery of no bile at all. Negative findings do not necessarily mean there is no disease present.

Pancreatic Disease

Much help has been afforded diagnosis of pancreatic disease in recent years by the use of the duodenal tube. Various techniques have been devised to study the recovered pancreatic secretion chemically and for cellular pathology.

In 1952, as an example, Walter Palmer and Joseph Kirsner[11] published their article on "The Present Status of Exfoliative Cytology in the Diagnosis of Gastro-Intestinal Malignancy." They stated that diagnostic biliary drainage offers the opportunity to diagnose carcinomas completely inaccessible to the roentgen ray and other modern methods. In 140 duodenal drainages there were 55 patients with malignancy. Two-thirds of these carcinomas of the gallbladder, bile ducts, and pancreas exfoliated well preserved malignant cells into the duodenum resulting in a correct positive diagnosis. Evidence of malignancy was obtainable twice as often by this method as was definite radiologic evidence. They suggested that it would be desirable to examine by this method all cases of obstructive jaundice early in their course. Undiagnosed upper abdominal symptoms with negative roentgen-ray studies may merit this procedure.

Intrahepatic Cholestasis

Recently, Hans Popper[18] published his article entitled "Anatomy of the Intrahepatic Biliary System and the Pathogenesis of Intrahepatic Cholestatic Jaundice." There, he pointed out the formation of bile duct plugs. Also, he found many instances in which bile pigment casts are not only seen in bile canaliculi, but also microcalculi in bile ductules and septal bile ducts. He emphasized the presence of rich fluid and cellular exudate in cholangiolitic biliary cirrhosis. In biliary cirrhosis associated with mucoviscidosis he found lakelike accumulations of abnor-

mal bile and mucus in the sinusoids as well as within distended bile ducts.

I have seen bile duct casts from the larger ducts and have identified excess shedding of bile duct lining epithelial cells in cases of cholangitis studied by diagnostic biliary drainage.

Biliary Tract Dysfunction

The duodenal tube gives us the most practical method at present to differentiate the functional from the organic diseases. In 1934, Ivy stated that "the trend of modern medicine toward the early diagnosis of diseases has led to an increased interest in functional disturbances which may precede or even cause organic changes of structure."

Biliary dyskinesia is a motor dysfunction of the biliary tract. It may be divided into primary biliary dyskinesia, which is that occurring in the absence of bile tract organic disease, and secondary, which is that occurring in the presence of bile tract organic disease. Dyskinesia has been attributed to such etiologic factors as reflex, endocrine, nervous, toxic, and constitutional. Secondary dyskinesia may accompany chemical irritation of bile, calculi, cholangitis, or mechanical irritation, such as an anomaly or deformity.

As early as 1934, Ivy[5] studied the effects of secretin-cholecystokinen injections on the duodenal secretions of normal humans. During the drainage of bile there was a sudden cessation of flow and the patient began to experience pain in the right upper quadrant of the abdomen. The instillation of magnesium sulfate through the tube to the duodenum resulted in resumption of a rapid flow of bile and disappearance of pain. He attributed the cessation of bile flow to a spasm of the sphincter of Oddi.

In 1934 in another paper,[4] Ivy pointed out that hyperplasia of the rugae and lymphoid tissue of the gallbladder may be produced in the dog by biliary stasis caused by stricture of the common duct or reversed loops of the duodenum. A hypertonic sphincter of Oddi or abnormal duodenal motility may cause stasis and hypertrophy of the gallbladder mucosa. The sphincter of Oddi can resist up to 75 cm. of bile pressure, whereas the maximum expulsive pressure of the normal gallbladder is 30 cm. Therefore, it is possible for a spastic sphincter or duodenum to prevent gallbladder evacuation.

Conclusion

Some of the accepted indications for diagnostic biliary drainage have been outlined. It is assumed that the procedure will be performed by a trained person and in the proper manner. In closing, may I quote from the preface in my handbook on diagnostic biliary drainage:[3] "Many physicians and technicians have tried to shorten the time of the procedure with resulting lessening of its diagnostic efficiency. The procedure is a meticulous one, and at best, is only an aid to diagnosis, although an important one. Carelessness in performing this procedure increases the probability of error and decreases the opportunity of detecting pathologic entities in the bile."

REFERENCES

1. Hall, A. A.: Medical Review of 311 Cholecystectomies and Importance of Diagnostic Non-Surgical Biliary Drainage, Ohio M. J. 37:1156-1158 (Dec.) 1941.
2. Hall, A. A.: Survey Method of Diagnosing Gastro-Intestinal Problem Cases, Ohio M. J. 43:165-166 (Feb.) 1947.
3. Hall, A. A.: Diagnostic Biliary Drainage, published by author, copyright 1956.
4. Ivy, A. C., and Bergh, G. S.: Applied Physiology of Extrahepatic Biliary Tract, J.A.M.A. 103:1500-1504 (Nov. 17) 1934.
5. Ivy, A. C., and Sanblom, P.: Biliary Dyskinesia, Ann. Int. Med. 8:115-122 (Aug.) 1934.
6. Kyle, L. H.; McKay, D. G.; and Sparling, H. J., Jr.: Strongyloidiasis, Ann. Int. Med. 29:1014-1042 (Dec.) 1948.
7. Lyon, B. B. V.: Diagnosis and Treatment of Diseases of Gall-Bladder and Biliary Ducts; Preliminary Report on New Method, J.A.M.A. 73:980-982 (Sept. 27) 1919.
8. Machella, T. E.: Diagnosis of Diseases of Gall-Bladder, Gastroenterology 34:1050-1059 (June) 1958.
9. Meltzer, S. J.: Am. J. M. Sc. 153:469 (April) 1957.
10. Mitty, W. F., Jr., and Rousselot, L. M.: Cholesterosis of Gall-Bladder, Gastroenterology 32:910-916 (May) 1957.
11. Palmer, W., and Kirsner, J. B.: Present Status of Exfoliative Cytology in Diagnosis of Gastro-Intestinal Malignancy, Gastroenterology (May) 1952.
12. Piersol, G. M.; Bockus, H. L.; and Shay, H.: Diagnostic Value of Duodenal Drainage in Gall-Stone Disease; With Special Reference to Significance of So-Called Bilirubin Calcium Pigment, Am. J. M. Sc. 175:84-96 (Jan.) 1928.
13. Popper, H.: Anatomy of Intrahepatic Biliary System and Pathogenesis of Intrahepatic Cholestatic Jaundice, Gastroenterology 34:1028-1033 (June) 1958.

Dr. Hall, 222 Medical Professional Building, San Antonio.

The best materials for use in tuberculin skin testing, methods for their use, and interpretation of results are discussed. Proper follow-up for positive reactors is outlined. The value of survey type testing is considered. Cross reactions, especially as related to group I anonymous mycobacteria, are discussed.

Treatment of Positive Tuberculin Reactors

JOHN S. CHAPMAN, M.D.

Dallas, Texas

NO DISCUSSION of the treatment of tuberculin reactors is possible without some understanding of the materials used and the interpretation of reactions. Of the materials available at present three are in general use: old tuberculin (O.T.), a purified protein derivative of old tuberculin (PPD), and the Volmer patch test. Of these materials the Volmer patch test has in local experience proved to be the least reliable and always to call for a confirmation by means of some type of intradermal test. In a number of studies PPD, in a dose of 5 tuberculin units, was found to be comparable to O.T. 1/1,000. For routine testing of large groups these two materials are about equal and are about as reliable substances as can be obtained.

The usual method of administration is the intradermal injection of 0.1 ml. of the appropriate solution of material. The reaction should be read in 72 hours, but if it is possible, it should be read both at 48 and at 72 hours.

In England a different method, consisting of the introduction of a tuberculin by means of a multiple puncture plunger, is being widely used in large scale testing. This so-called Heaf test apparently produces results very similar to those obtained by the intradermal injection of O.T. or PPD. In extensive testing it has the advantage of being much more rapid and in the case of infants and young children of being less frightening than the intradermal method.

The reading of the skin test should be accomplished primarily through palpation to discover the bounds of induration present. If erythema alone is present, it should be regarded as a questionable reaction, demanding a repeat test. A reaction of less than 5 mm. induration is negative, while any reaction greater than 5 mm. in diameter is positive. A number of investigators challenge this concept and indicate that most significant reactions are 10 mm. or more in diameter. My method is to measure the induration at two right angled axes and express them in terms such as 10 by 12 mm. The interpretation of the 5 to 10 mm. reaction is subject to much question and will be discussed under a separate heading somewhat later. Very large reactions, that is, from 15 to 25 mm., are viewed by the English as indicating very recent, very heavy, or potentially dangerous infections. It is certainly true, according to their statistics, that persons with larger reactions have a greater propensity to the development of significant and manifest disease.

Doubtful reactions, slight indurations, and areas of erythema may be followed by one of two meas-

ures. The first of these consists of retesting with a stronger concentration of the material such as second strength PPD or 1/100 O.T. The other method, that which I have used most frequently, consists of repeating the test with the same dose in a period of 4 to 6 weeks. It should be remembered that children who have recently had pertussis or measles may well be temporarily anergic, that very recent infections may not yet have produced sufficient allergy to result in a reaction, and that very ill children may be anergic to any amount of testing material used. In such instances periodic retesting appears to be the safest and wisest procedure.

Follow-Up on Positive Reactor

When the skin test has produced an unmistakable reaction, the next problem that arises is the proper disposition of the child who reacts. The child should be examined by roentgen ray and studied clinically for evidence of active primary disease. If the reaction is small, the best procedure seems to be to repeat the skin test in about a month to see if it will be clearly larger. The same statement applies to those patients who present a questionable erythema without definite induration. The disposition of a negative reactor depends entirely upon the situation that is known to exist or that can be determined to exist within his family.

If the family is known to contain an individual who has active tuberculosis or who has arrested tuberculosis and the child or children present negative skin tests, the proper follow-up will consist of repeated testing of the children at intervals, sometimes as close as 4 weeks, until the skin test should have become positive or until it becomes apparent from repeated testing that the risk of infection has ceased. After perhaps 3 or 4 months of testing the child may then be tested at intervals as far apart as 3 months, and ultimately after some period of observation he may be retested as often as only once a year.

In the case of households in which there is a known active and open case of tuberculosis a single negative skin test in a child is not sufficient to relieve that child of further surveillance. Special situations exist in which anergy may well be expected: these are infancy, when a child may have rather large lesions and even miliary tuberculosis without having a positive skin test; severe and pneumonic tuberculosis in somewhat older children; and other recent infections such as measles which are frequently followed by short periods of anergy.

In all of these cases retesting is necessary, but if the child is clinically ill, or even though clinical symptoms are minor, in the child under 1 year of age who comes from a known tuberculous household it is advisable to obtain roentgenograms regardless of the reaction to the skin test. In the case of older children who are negative they should be retested as often as every 2 or 3 weeks until at least 3 months after contacts have been broken. There is no evidence whatever that repeated skin testing will in itself produce a reaction to a subsequent test.

Community Surveys

Another type of study is frequently introduced into a community for various reasons. This constitutes the so-called survey type skin testing program. Such a program introduced into a school, particularly in the first grade when it may be assumed that most of the infections have arisen at home, may serve useful purposes in the community. Aside from aspects of public relations and public education the positive reactors among the first graders should lead in some cases to discovery of new and hitherto unknown cases of tuberculosis in the adult population. Among the siblings active primary tuberculosis may also be encountered.

Such a program, however, should not be undertaken without certain definite points in mind. The first of these is that every positive reaction that is found should lead to a roentgenogram and follow-up films. The second point is that the families of all positive reactors should be thoroughly studied. If such follow-up leads to discovery of no new cases but in every case leads to an individual who is already on the tuberculosis roster, this information serves to determine the accuracy of that roster. Finally, such a program, once it is introduced, should be continued as a regular process, and indeed the ideal would be to test yearly all children who were negative reactors in the preceding year.

Dr. John S. Chapman, professor of internal medicine at the University of Texas Southwestern Medical School, read this paper before the Texas Academy of General Practice in Galveston, October 6, 1959.

For maximum results from this type of testing it is good to have some background material, which consists of a general knowledge as to the amount of tuberculosis in the population at any one time. The infection rate, as measured by the skin test, will vary

from one place to another, from one social and economic stratum to another, and perhaps even from one year to another. The accompanying diagram indicates that in the city of Dallas the lowest social and economic stratums have the highest rate of tuberculous infection, that certain geographic sections of the city contain more tuberculosis than others, that middle income areas generally fall in about the middle so far as rate of infection is concerned, and that the highest economic areas are those most free of tuberculosis. These figures also indicate that even for the lowest economic stratums the incidence of a positive skin test is only about 3 per cent at the age of 6 years. As of 1948, however,

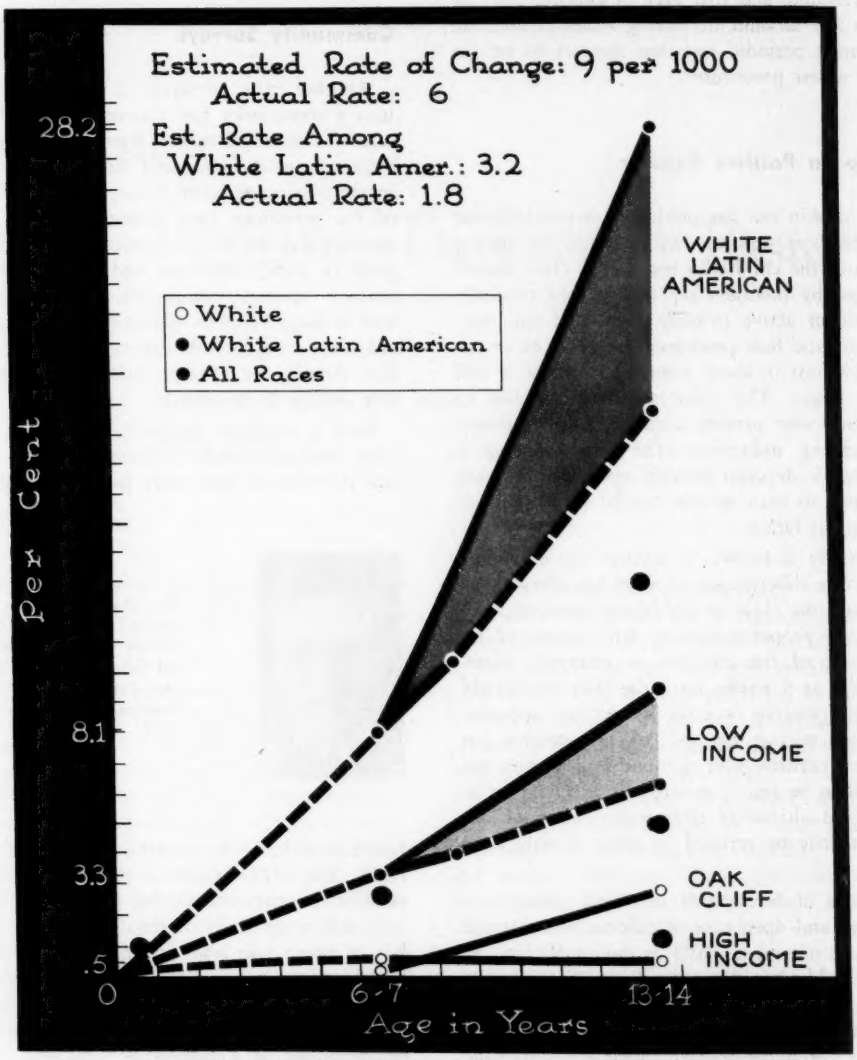


Fig. 1. Positive tuberculin skin tests in a Dallas survey.

Upper graph is for white Latin Americans in Dallas. Note the difference (shaded area) between expected rate of conversion and actual rate. The large black dot indicates that 2 years later 14 year old children were only 13 per cent positive.

Middle graph is a composite of all low income groups regardless of race. Shaded area represents difference between projected rate of conversion (upper line) and actual (lower). Large black dots represent tests on first and eighth graders 2 years later.

Oak Cliff line represents all Anglo middle income group and bottom line refers to all Anglo high income group.

the incidence was much higher than that, when the average for the city of Dallas in all tenth graders was approximately 14.5 per cent. Indeed as the classes are followed from one year to another, as indicated in the diagram, it is seen that the expected rate of conversion from negative to positive is less than that which would be predicated upon a line drawn from the determined point at the age of 6 years to the determined point at the age of 13 or 14 years. The indication is therefore that the infection rate is steadily falling, an observation that has been made in other cities in recent years.

The same remarks would apply to any surveys undertaken in colleges, industries, or any other specific groups. The question of preliminary skin testing in certain industries is one of particular moment since the question of irradiation exposure has arisen. While it is perfectly possible for a patient to have yearly test films throughout his life without receiving any significant exposure, the number of people exposed to roentgen ray can be reduced, of course, by a preliminary skin testing program. From the standpoint of management, however, this means taking people off their work initially for the skin test, somewhat later for the reading of the skin test, and finally for a roentgenogram. Since industrial surveys produce many more significant findings than tuberculosis alone and since the time required for such studies would be at least three times as long as for roentgen examination alone, it would seem in view of the very small roentgen-ray exposure involved that in industrial groups it would be preferable to continue the use of the mobile unit type of survey.

If one carries out serial testing on a series of young persons a certain number, perhaps as many as 2 or 3 per 1,000, will become positive each year. The problem arises as to the proper disposition of these individuals. It is a well known fact that the hazard of extrapulmonary and of hematogenous disease is greatest during the first year after conversion of the skin test[5] and that in the course of their lives a considerable number of these converters will develop manifest pulmonary tuberculosis. For this reason it is necessary to keep a close and continuous roentgen-ray surveillance over all such converters.

A pertinent question is whether more than this should be done. A recent study on the prevention of tuberculous meningitis which has just been carried out by the United States Public Health Service[2] indicates that such a severe complication as meningitis can be prevented in about 80 per cent of children less than 3 years of age if they are treated with isoniazid at the rate of 4 to 5 mg. per kilogram of body weight and continued on that drug for 1 year. Unfortunately the study is too recent to allow any conclusions as to the development of bacterial resistance to isoniazid, and of course the follow-up of these patients is comparatively short at this time. Nevertheless it would certainly seem to be true that the great majority of children, especially those in whom a close surveillance cannot be maintained, should be placed on prophylactic isoniazid. Probably a somewhat similar statement might be made in regard to older children who are known to have become positive within the previous year.

Cross Reactions

Finally, some discussion of possible cross reactions is indicated. There is no evidence at all that cross reactions between antigens for the fungi and antigens for tuberculosis take place. It is well known, however, that in certain parts of the country there appear to be frequent infections with mycobacteria other than tuberculosis,[1] and it appears from recent work at Southwestern Medical School that a moderate degree of cross reaction may occur between the skin antigens for tuberculosis and those for other mycobacteria. A similar observation has been made in Georgia where the group III (Battey) strains are very frequent and produce a number of smaller and questionable reactions to tuberculins.

At this time early information suggests that in the Texas area the group I mycobacteria, the so-called photochromogens, are prevalent in the general population and may likewise account for a considerable number of cross reactions.[4] Indeed the results at this time are such as to suggest that there is a higher degree of cross reaction between the group I mycobacteria and human tuberculosis than between the group III mycobacteria and human tuberculosis. Unfortunately no commercial supply of such materials is available.

One point that seems to have emerged from the early studies is that the person who reacts to old tuberculin but not to PPD may in fact have derived his allergy from one of the anonymous mycobacteria.[3] It is also conceivable and even probable that a certain number of individuals in this area may have developed infection from both human tuberculosis and one of the mycobacteria so that when reactions to PPD and to one of the mycobacterial antigens are of about the same magnitude the suggestion is less that of cross reaction than that of a double infection.

Summary

Materials, methods, and problems of interpretation in regard to the tuberculin skin test have been presented.

A proper follow-up program for positive reactors has been outlined.

A discussion of community tests has been undertaken, and the advantages and disadvantages have been presented.

The problem of cross reactions has been discussed, particularly as it relates in the Texas area to group I anonymous mycobacteria.

REFERENCES

1. Edwards, L. B., and Palmer, C. E.: Epidemiologic Studies of Tuberculin Sensitivity, Am. J. Hyg. 68:213 (Sept.) 1958.
2. Ferebee, S.; Mount, F. W.; and Anastasiades, A.: Prophylactic Effects of Isoniazid on Primary Tuberculosis in Children; Preliminary Report, Am. Rev. Tuberc. 76:942 (Dec.) 1957.
3. Freeman, S.: Unpublished data.
4. Lefkowitz, L. B., Jr.; Sanford, J. P.; and Chapman, J. S.: Skin Tests with "Tuberculins" Prepared from Atypical Mycobacteria; Clin. Res. Vol. 8 (Jan.) 1960.
5. Wallgren, A.: Time Table of Tuberculosis, Tubercle. 29:245 (Nov.) 1948.

Dr. Chapman, Division of Postgraduate Education, University of Texas Southwestern Medical School, 5323 Harry Hines Blvd., Dallas 35.

Studies of Cardiac Rhythm During Anesthesia And Administration of Oxytocics

Electrocardiographic changes following the administration of Pitocin and Syntocinon in the third stage of labor, and Pitocin in dilute solution during labor and delivery were studied in 125 patients. Transient changes in cardiac rhythm, principally of supraventricular locus, were observed in 5 of 51 patients that received Pitocin and 12 of 70 that were given Syntocinon.

ROBERT T. CAPPS, M.D.
Seattle, Washington
JACK A. GRAY, M.D.
Fort Hood, Texas

PREPARATIONS of Pitocin usually contain small amounts of Pitressin. Since this substance is thought to be responsible for some of the untoward effects of Pituitrin, there has been reluctance on the part of many obstetricians to use Pitocin when cyclopropane was being administered. Morris, Thornton, and Harris,[15] in 1952, studied a series of patients in whom ergonovine, Pituitrin, and Pitocin were administered while they were anesthetized with cyclopropane for delivery.

Their results showed a significantly greater percentage of cardiac disturbances following the administration of Pituitrin than following the use of Pitocin during cyclopropane anesthesia. They suggested that the use of Pituitrin should be avoided. These workers observed cardiac arrhythmias of ventricular origin when ergonovine, Pitocin, and Pituitrin were administered during cyclopropane anesthesia. However, they indicated that these changes were not significantly greater than were found in a study of cyclopropane anesthesia in which no oxytocics were administered.

Although allusions to the danger of the combination of Pitocin and cyclopropane have been made[6] in the years since the report of Morris and others,[15] only one report has appeared in the literature[14] in

which deleterious effects are described following the administration of Pitocin to a patient who had received cyclopropane. In this instance, the oxytocic was administered intravenously, the dose used was relatively large, and from the protocol presented, the contribution of cyclopropane to the fatal result is open to some question.

Recently a synthetically prepared oxytocic, Syntocinon, with oxytocic properties equivalent to Pitocin has been introduced clinically.[1-5, 7, 8, 10-12] This compound theoretically should produce less cardiovascular changes than Pitocin prepared from animal sources that is known to contain some Pitressin or vasopressin. However, some vasopressor activity of the synthetic drug has been shown in experimental animals,[18] and Francis and Francis[10] suggested that the drug probably possesses slight pressor activity in clinical use. Dillon and others[7] measured blood pressure following the administration of Syntocinon and observed that there were no abnormal levels that could be separated from other causes of hypertension.

Mayes and Shearman[16] found that 2 to 5 units of Syntocinon injected intravenously in patients reduced the blood pressure and produced depressed or inverted T waves in the electrocardiogram. Feldman and associates[9] recently reported both decreases and increases in blood pressure, but no electrocardiographic abnormalities, when Syntocinon was administered to dogs anesthetized with cyclopropane. Bergquist and Kaiser[2] investigated the effects of Syntocinon administered intravenously in conscious patients in the postpartum period and observed a brief fall in blood pressure followed by a small increase in it 5 minutes after injection. Electrocardiographic changes recorded in their study of 100 patients were a decrease in the height of the T wave with inversion of it in three instances, depression of the S-T segment, and prolongation of the Q-T interval.

In an attempt further to confirm the work of Morris, Thornton, and Harris with Pitocin and to obtain a comparison of the effects of Syntocinon with Pitocin during anesthesia, the present study was undertaken.

Material and Methods

Patients were chosen at random in the delivery rooms of Parkland Memorial Hospital. The only attempt at selection of patients was an effort to study as many as possible of those who were receiving Pitocin or Syntocinon intravenously for stimulation or induction of labor. With a direct-writing electrocardiograph, control records from the standard limb leads were obtained before any anesthetic agents were administered. The pattern of deflection of the stylus was observed constantly thereafter and records were made at intervals during delivery and then every minute or two for 10 to 20 minutes following the administration of the oxytocics. Blood pressures were recorded by auscultatory methods by the person administering the anesthetic agents.

In those patients receiving inhalation anesthesia, usually only nitrous oxide and oxygen in a ratio of 3 liters per minute of nitrous oxide and 1.0 liter per minute of oxygen were administered intermittently during uterine contractions before delivery. When ether and/or cyclopropane were used before delivery, they usually were added to the nitrous oxide-oxygen mixture when delivery of the presenting part was imminent to provide additional analgesia for episiotomy and/or relaxation for application of forceps. Pontocaine, 0.2 per cent (4.0 mg.) was administered intrathecally as a "saddle block." An epidural block with Xylocaine, 1 per cent, was used in 3 patients and pudendal block with this agent in 2 patients. Pitocin and Syntocinon were administered intramuscularly in doses of 10 units (1.0 ml.) or intravenously in dilute solution with 10 units of oxytocic to 500 ml. of 5 per cent dextrose in water. The electrocardiograms obtained were analyzed for changes in rate and rhythm throughout the procedure and for changes in length of P-R interval, height of the T wave, and alterations in S-T segment in lead II approximately 5 minutes and 10 minutes after administration of the oxytocic.

Dr. Robert T. Capps and his coauthor, Dr. Jack A. Gray, then with the Department of Anesthesiology at the University of Texas Southwestern Medical School, Dallas, presented this paper at the annual meeting of the Texas Society of Anesthesiologists, April 21, 1959, in San Antonio.

Results

The anesthetic agents and combinations of them that were used in the 125 patients studied are shown in table 1, along with the oxytocics employed and the route by which they were administered. Approximately one-half of the patients received only nitrous oxide analgesia, and slightly less than one-third were anesthetized with cyclopropane or cyclopropane with nitrous oxide. It was contemplated that the 13 patients in whom regional analgesia with Pontocaine or Xylocaine was used would serve as controls for the patients receiving inhalation anesthesia.

Fifty-one patients received Pitocin, 70 received Syntocinon, and 4 patients received both oxytocics, an infusion of dilute solution of Pitocin being administered some time after Syntocinon had been given intramuscularly because of unsatisfactory uterine contraction following the first oxytocic. The greatest number of deliveries were spontaneous, but 14 deliveries with forceps and 2 cesarean sections were included in the group. In the majority of the spontaneous deliveries, the anesthetic consisted of only nitrous oxide and oxygen administered intermittently with contractions, continuously during delivery, and then discontinued at the time the oxytocic was given or even before this time in some cases.

Electrocardiographic abnormalities following the administration of Pitocin were much less frequent than anticipated; only 5 of the 51 patients in this group were found to have changes. As can be seen from the top portion of table 2, these alterations were of supraventricular location in all instances. A particular change is counted only once in a patient, regardless of how many times it occurs, but since some patients had more than one change, the total number shown is greater than the number of patients having the changes. In 2 instances where changes in rhythm occurred, 1 with nitrous oxide-cyclopropane-ether, and 1 with Pontocaine, the Pitocin was administered as an intravenous infusion, and in the others the drug was given intramuscularly.

TABLE 1.—*Anesthetics and Oxytocics Used in 125 Patients.*

Anesthetic Agents	Pitocin IM	Pitocin IV	Pitocin IM IV	Syntocinon IM	Syntocinon IV	Syntocinon IM IV	Total
Nitrous oxide	15	2	2	35	1	1	56
Cyclo & N_2O-cyclo	11	4	2	20		1	38
N_2O-cyclo-ether	2	2		4			8
N_2O-ether	3			3			6
Pontocaine	3	2		3			8
Xylocaine	1	1	1	2			5
Nitrous oxide		x		(x)			1
N_2O-cyclo-ether		x		(x)			3
Total	35	15	5	67	1	2	125

TABLE 2.—*Electrocardiographic Changes Following the Administration of Oxytocics.*

Anesthetic Agents	No. Patients*	Type of Change† SAPC	AVB	AVR	AVPC	VPC
PITOCIN						
Cyclopropane	1	1			1	
N_2O-cyclo-ether	2	1		1	2	
Pontocaine	2		1	1		
SYNTOCINON						
Nitrous oxide	2		1	2		
Cyclo & N_2O-cyclo	7	1		4	1	1
N_2O-cyclo-ether	3			3		

*Number of patients having changes.

†SAPC—auricular premature contraction, AVB—auriculoventricular block, AVR—auriculoventricular rhythm, AVPC—auriculoventricular premature contraction, VPC—ventricular premature contraction.

Following the administration of Syntocinon (lower portion of table 2), electrocardiographic changes occurred in 12 patients, each of whom received inhalation anesthetics. Shortening of the P-R interval to less than 0.12 of a second or complete disappearance of the P wave indicating that the pacemaker was in the atrioventricular node, designated as A-V nodal rhythm (AVR), was the most frequent change in this group. A single ventricular premature contraction appeared on 2 occasions in 1 patient who was anesthetized with nitrous oxide and cyclopropane. Other changes of supraventricular origin were present as indicated in the table. All of the changes that occurred were following the intramuscular administration of the drug. The changes in cardiac rhythm observed following administration of the oxytocics were transitory; they appeared at intervals varying from 1 to 35 minutes after the drugs had been given, and the condition of the patients was unchanged clinically. No definite relationship of the time of administration of the oxytocic to appearance of the arrhythmia could be determined.

In the 4 patients that received both Syntocinon and Pitocin, A-V nodal rhythm appeared in 2 that were anesthetized with nitrous oxide-cyclopropane-ether mixtures. In 1 patient, the change occurred following the administration of Syntocinon, but reverted to sinus rhythm when the infusion of Pitocin was started. In the second instance, the change in pacemaker occurred 7 minutes after the infusion of Pitocin had been started and continued for the remaining 10 minutes of the recording.

In each group, there were patients in whom some transient electrocardiographic abberation occurred after the anesthetic was started, but prior to the administration of the oxytocic. Such changes occurred with each of the anesthetics used, except Xylocaine as employed for pudendal block. However, the number of patients having these changes (only 11) was much less than had been expected on the basis of previous experience. Electrocardiographic alterations were present in a few cases at the time the oxytocic was given, or changes that had been present before the drug was injected reappeared after its administration. On these occasions it was not possible to determine whether the change was due to the effect of the anesthetic or the oxytocic, and these changes, which occurred in 8 patients (3 Pitocin, 5 Syntocinon), were not tabulated with those which occurred only after the administration of the oxytocics.

Changes in P-R Interval.—The duration of the P-R interval at approximately 5 and 10 minutes after the administration of the oxytocic was compared to the duration of it in the control record to

estimate whether or not the oxytocic altered the conduction time of the impulse through the auricle and A-V node. Table 3 shows the data for Pitocin with the various anesthetic agents, tabulated as to whether the interval was shorter than, equal to, or longer than the control figure. In the patients that received nitrous oxide analgesia only, the interval tended to be longer than the control at both 5 and 10 minutes. With cyclopropane or nitrous oxide-cyclopropane, the duration of the P-R interval at 5

TABLE 3.—*Changes in P-R Interval Following the Administration of Pitocin.*

Anesthetic Agents	5 minutes			10 minutes		
	Shorter	Equal	Longer	Shorter	Equal	Longer
Nitrous oxide	5‡	5	9	5	5	9
Cyclo & N_2O-cyclo*	7	3	5	5	5	5
N_2O-cyclo-ether†	1	1	1	1	1	1
N_2O-ether	1	1	1	2	1	
Pontocaine	3	2		4	1	
Xylocaine		1	2		1	2

No control record before oxytocic added—*2 patients, †1 patient.
‡Number of patients.

minutes after the injection was less than the control in almost one-half of the patients. But at 10 minutes, one-third of the patients were in each group.

When Syntocinon was the oxytocic (table 4), the changes in P-R interval in the patients that received nitrous oxide analgesia were in the same direction as in the case of Pitocin, that is, longer duration. With cyclopropane or nitrous oxide-cyclopropane anesthesia, the data at both 5 and 10 minutes after administration of the oxytocic indicate a shortening of the P-R interval in a majority of the patients. The

TABLE 4.—*Changes in P-R Interval Following the Administration of Syntocinon.*

Anesthetic Agents	5 minutes			10 minutes		
	Shorter	Equal	Longer	Shorter	Equal	Longer
Nitrous oxide	6*	14	17	5	11	21
Cyclo & N_2O-cyclo	11	7	3	11	8	2
N_2O-cyclo-ether	1	2	1		3	1
N_2O-ether	1	1	1	1	1	1
Pontocaine		2	1		2	1
Xylocaine	1		1	1		5

*Number of patients.

number of patients in which the other agents were used did not warrant drawing valid conclusions about the changes. The changes observed with each oxytocic were minimal, and the P-R interval only occasionally was increased to more than 0.20 of a second.

T wave.—Changes in the amplitude of the T wave in lead II following the administration of Pitocin as related to the amplitude in the control record are shown in table 5. In those patients who received nitrous oxide, cyclopropane, and cyclopropane with nitrous oxide, the T wave was taller than that of the control in one-half to two-thirds of the patients at the 5 minute and 10 minute periods. Following the administration of Syntocinon (table 6), the changes in the T wave when only nitrous oxide had been administered generally were much the same as those with Pitocin, and at the 10 minute interval, the percentages were approximately the same with each oxytocic. With cyclopropane and nitrous oxide-cyclopropane, a little more than one-half of the patients had no change 5 minutes after Syntocinon had been given, but at 10 minutes nearly 50 per cent of the patients showed an increase in the amplitude of the T wave. It also should be noted in this instance that there was an increase in T wave amplitude for

TABLE 5.—*Change in T Wave Following the Administration of Pitocin.*

Anesthetic Agents	5 minutes			10 minutes		
	Lower	Equal	Taller	Lower	Equal	Taller
Nitrous oxide	2‡	6	11	4	3	12
Cyclo & N_2O-cyclo*	3	2	10	3	3	9
N_2O-cyclo-ether†	2	1		2	1	
N_2O-ether		2	1		3	
Pontocaine	4		1	3	1	1
Xylocaine			3			3

No control record before oxytocic added—*2 patients, †1 patient.
‡Number of patients.

more patients at the 5 minute period than at the 10 minute one. Although conclusions regarding the effects during the other agents are not possible with the amount of data obtained, when Pitocin was administered to the patients that had received Pontocaine, there was a trend toward a lowering of the T wave at each period surveyed.

S-T segment.—The alterations in the S-T segment in lead II, or actually the junction or J point in the parlance of the cardiologist, were minimal. In the majority of the patients that received Pitocin, this measurement was unchanged from the preanesthetic recording. When Syntocinon was the oxytocic, the changes were the same as with Pitocin except in the nitrous oxide-oxygen group where there were a greater number of patients showing some elevation of the S-T segment 10 minutes after administration of the oxytocic. During the administration of

TABLE 6.—*Changes in T Wave Following the Administration of Syntocinon.*

Anesthetic Agents	5 minutes			10 minutes		
	Lower	Equal	Taller	Lower	Equal	Taller
Nitrous oxide	11*	5	21	9	6	22
Cyclo & N_2O-cyclo	4	11	6	6	5	10
N_2O-cyclo-ether	2	1	1		2	2
N_2O-ether	1		2	2		1
Pontocaine		2	1		1	2
Xylocaine	1		1	1		1

*Number of patients.

the other anesthetic agents, a few patients had depression of the S-T segment and another small number had some elevation of it. With each anesthetic or combination used, however, most of the patients demonstrated little deviation from the control level. The alterations in all instances were slight (less than 2 mm. in either direction) and not indicative of myocardial ischemia.

Blood Pressure.—In those patients in whom a satisfactory number of recordings were obtained, there were no striking alterations in the blood pressure. There were a few instances in which either increases or decreases of 10 to 20 mm. of mercury in both systolic and diastolic pressure occurred, but these could not be related to the administration of the oxytocic.

Induction of Labor.—It was felt that patients receiving the oxytocics intravenously before anesthesia was started possibly would show more marked changes than those who received the agents in the usual order. Six patients receiving a dilute solution of Pitocin intravenously for induction of labor were studied. Two of these received cyclopropane anesthesia at the time of delivery, 1 was anesthetized with nitrous oxide-ether-cyclopropane, and 1 each of the others received nitrous oxide-oxygen, Pontocaine, and Xylocaine. The patient anesthetized with the nitrous oxide-ether-cyclopropane mixture had occasional auricular and A-V nodal premature contractions 22 minutes after the start of the anesthetic. The patient who had spinal anesthesia developed A-V block just at the end of the procedure.

No changes in cardiac rhythm were observed in 3 patients. In the remaining one, ventricular premature contractions present prior to anesthesia disappeared during the induction of anesthesia with cyclopropane, but reappeared when the cyclopropane concentration was reduced just before delivery of the infant. At the conclusion of the procedure, at which time the patient was awake, the premature ventricular contractions were slightly more frequent than antepartum. Two days later, the electrocardiographic pattern was the same as noted during the prenatal period. Although the record from this patient shows a change in the P-R interval and displacement of the pacemaker, the T waves and S-T segments remained unchanged. In the other patients that were given Pitocin intravenously, there were some slight changes in the P-R interval and in the height of the T waves but no other changes.

Discussion

This investigation was designed primarily to study the effects of the oxytocics as they are used clinically during the administration of the commonly used anesthetics. Particular emphasis was directed toward cyclopropane since the use of Pitocin in the presence of this agent has been subject to so much discussion. Other agents were included for comparative purposes as well as for evaluation with the new oxytocic. There were fewer changes of cardiac rhythm in the patients of the present study that were given Pitocin than were observed by Morris, Thornton, and Harris.[15] Some of this difference may be due to the use of nitrous oxide with the cyclopropane in most of the patients of the present series, which would tend to reduce the concentration of cyclopropane in the mixture and keep the level of anesthesia lighter. Although the changes of cardiac rhythm that were found following the administration of Syntocinon during cyclopropane anesthesia were somewhat more frequent than those that occurred after the use of Pitocin, they were principally of supraventricular origin and were not considered to be serious.

The changes in the P-R interval and the S-T segment or junction are probably of academic interest more than of clinical significance. The variations for the most part were small and transient and represent negative results more than positive ones.

The changes in the T wave found in the present study when Syntocinon was used are of some interest in view of the findings of Mayes and Shearman[16] and Bergquist and Kaiser[2] with this drug. When cyclopropane or cyclopropane with nitrous oxide was used, it might be postulated that the increased amount of oxygen in the inspired atmosphere could account for the T wave usually remaining equal to the control figure or being increased over that value. In the patients who had only nitrous oxide analgesia, however, the anesthetic mixture usually had been stopped at or before the time of injection of the oxytocic, and the patient was allowed to breathe room air. Thus, by the time the 10 minute record was taken, the patient had received no supplemental oxygen for several minutes, and yet, the T waves were equal to or higher than the control value in 28 of the 37 patients (75 per cent) of the group. The 9 patients (25 per cent) in whom the T waves were lower than the preanesthetic value is approximately the same, on a percentage basis, as was found by Bergquist and Kaiser following intravenous administration of Syntocinon. It is only slightly greater than was noted following the use of Pitocin (21 per cent) in the present study. Among the patients in whom the amplitude of the T wave was diminished, there were some in whom it was noted to be isoelectric after the injection of the oxytocic, but there were none in which the T waves became inverted.

The data here are not strictly comparable to the work of Mayes and Shearman or Bergquist and Kaiser since their observations were made following the intravenous administration of the drug. Another

factor which may be partially responsible for the alterations in the T wave observed in this study, and which may account for the difference from the results of other investigators, is the shift in the axis of the heart. This may occur, first, with changes in position of the patient and, second, following the emptying of the uterus which would permit a greater excursion of the diaphragm. A number of the control records in this study were obtained with the patients supine, either in the labor room bed or on the delivery table, whereas the electrocardiograms made following the administration of the oxytocics usually were made with the patient in the lithotomy position. Since notation of the position of the mother at the various periods was not made when the records were taken, the change which this may have produced cannot be stated.

A survey of the anesthetic records from the delivery suite at Parkland Memorial Hospital for the period covering the major portion of this study revealed that more than 100 additional patients during this time received Pitocin or Syntocinon during the administration of cyclopropane, alone or with nitrous oxide, without untoward effect. It is possible that this combination is used more frequently in other hospitals than generally has been appreciated. From our data, we can find no reason why these oxytocics should not be employed during cyclopropane anesthesia if so desired by the obstetrician.

Summary

Electrocardiographic changes following the administration of Pitocin and Syntocinon in the third stage of labor, and Pitocin in dilute solution during labor and delivery have been studied in 125 patients.

Transient changes in cardiac ryhthm, principally of supraventricular locus, were observed in 5 of 51 patients that received Pitocin and 12 of 70 that were given Syntocinon. The P-R interval tended to be increased in duration when nitrous oxide analgesia was used, and decreased when cyclopropane, alone or with nitrous oxide, was the anesthetic. Changes in the S-T segment were minimal, and in the majority of the patients it remained unchanged from the control value. The T wave, in general, tended to remain unchanged or become elevated following the administration of the oxytocics when the inhalation anesthetics were used.

The changes noted were minimal ones and were not accompanied by any discernible change in the clinical condition of the patients.

No contraindication to the use of Pitocin or Syntocinon during cyclopropane anesthesia could be found in the data obtained.

The assistance of Mr. John Berry and Miss Vivian Meinecke, R.N., in collection and preparation of the data is gratefully acknowledged.

REFERENCES

1. Bainbridge, M. N.; Nixon, W. C. W.; Schild, H. O.; and Smyth, C. N.: Synthetic Oxytocin, Brit. M. J. 1:1133-1135 (May 19) 1956.
2. Bergquist, J. R., and Kaiser, I. H.: Cardiovascular Effects of Intravenous Syntocinon, Obst. & Gynec. 13:360-364 (March) 1959.
3. Bishop, E. H.: Synthetic Oxytocin: Clinical Evaulation, Obst. & Gynec. 11:290-294 (March) 1958.
4. Boissonnas, R. A.; Guttmann, S. T.; Jaquenoud, P. A.; and Waller, J. P.: Une nouvelle synthese de l'oxytocine, Helv. Chim. Acta 38:1491-1501, 1955.
5. Caldeyro-Barcia, R., and others: Quantitative Study of Action of Synthetic Oxytocin on Pregnant Human Uterus, J. Pharmacol. & Exper. Therap. 121:18-31 (Sept.) 1957.
6. Crawford, J. S.: Anesthesia for Obstetrics; Recent Advances, Brit. Med. Bull. 14:34-37 (Jan.) 1958.
7. Dillon, T. F.; Bonsnes, R. W.; and Douglas, R. G.: Relative Obstetric Efficacy of Oxytocin, Pitocin and Syntocinon, Obst. & Gynec. 12:581-588 (Nov.) 1958.
8. Douglas, R. G.; Bonsnes, R. W.; and du Vigneaud, V.: Natural and Synthetic Oxytocin; Preliminary Report on Use of Both for Induction and Stimulation of Labor, Obst. & Gynec. 6:254-257 (Sept.) 1955.
9. Feldman, S. A.; Forgaard, D. M.; and Morris, L. E.: Compatibility of Synthetic Oxytocin (Syntocinon) with Anesthesia in Dogs, Anesthesiology 19:787-791 (Nov.-Dec.) 1958.
10. Francis, H. H., and Francis, W. J. A.: Clinical Trial of Synthetic Oxytocin, Brit. M. J. 1:1136-1137 (May 19) 1956.
11. Friedman, E. A.: Synthetic Oxytocin; Critical Evaluation in Labor and Post Partum, Am. J. Obst. & Gyn. 74:1118-1124 (Nov.) 1957.
12. Fugo, N. W., and Dieckmann, W. J.: Comparison of Oxytocic Drugs in Management of Placental Stage, Am. J. Obst. & Gynec. 76:141-146 (July) 1958.
13. Gyermek, L., and Fekete, G.: On Vasopressor and Antidiuretic Activities of Synthetic Oxytocin, Experientia 11:238-239 (June) 1955.
14. Lesser, M., and Eason, G. A.: Cardiac Arrest Under Anesthesia During Induction of Labour with "Pitocin" Drip, Brit. M. J. 2:79-80 (July 10) 1954.
15. Morris, L. E.; Thornton, M. J.; and Harris, J. W.: Comparison of Effect of Pituitrin, Pitocin, and Ergonovine on Cardiac Rhythm During Cyclopropane Anesthesia for Parturition, Am. J. Obst. & Gynec. 63:171-174 (Jan.) 1952.
16. Mayes, B. T., and Shearman, R. P.: Experience with Synthetic Oxytocin: Effects on Cardiovascular System and Its Use for Induction of Labour and Control of Third Stage, J. Obst. & Gynec. Brit. Emp. 63:812-818 (Dec.) 1956.

♦ Dr. Capps, Associate Professor of Anesthesiology, University of Washington School of Medicine, Seattle 5.
Dr. Gray, Capt., M.C., U.S.A., Fort Hood.

★ Coming Meetings

Texas Medical Association, Fort Worth, April 9-12, 1960. Dr. F. W. Yeager, Corpus Christi, Pres.; Mr. C. Lincoln Williston, 1801 North Lamar Blvd., Austin, Exec. Secy.

American Medical Association, Miami Beach, June 13-17, 1960. Dr. Louis M. Orr, Orlando, Fla., Pres.; Dr. F. J. L. Blasingame, 535 North Dearborn, Chicago 10, Exec. Vice-Pres.

Current Meetings

APRIL

American Academy of Pediatrics, Atlantic City, April 20-22, 1960. Dr. William W. Belford, San Diego, Calif., Pres.; Dr. E. H. Christopherson, 1801 Hinman Ave., Evanston, Ill., Executive Director.

American College of Obstetricians and Gynecologists, Cincinnati, April 3-6, 1960. Dr. John I. Brewer, Chicago, Pres.; Mr. Donald F. Richardson, P. O. Box 749, Chicago 90, Executive Secy.

American College of Physicians, San Francisco, April 4-8, 1960. Dr. Howard P. Lewis, Portland, Ore., Pres.; Mr. E. R. Loveland, 4200 Pine, Philadelphia 4, Secy.

American Dermatological Association, Boca Raton, April 8-12, 1960. Dr. Marion B. Sulzberger, New York, Pres.; Dr. Wiley M. Sams, 308 Ingraham Bldg., Miami 32, Secy.

American Proctologic Society, Houston, April 25-27, 1960. Dr. H. R. Reichman, Salt Lake City, Pres.; Dr. Norman D. Nigro, 10 Peterboro, Detroit 1, Secy.

American Surgical Association, White Sulphur Springs, W. Va., April 3-6, 1960. Dr. Warren H. Cole, Chicago, Pres.; Dr. William Altemeier, Cincinnati General Hospital, Cincinnati 29, Secy.

Southwest Allergy Forum, Oklahoma City, April 2-5, 1960. Dr. Johnny A. Blue, Oklahoma City, Pres.; Dr. George L. Winn, Suite 104, Lister Medical Building, 430 Northwest Twelfth St., Oklahoma City, Secy.

United States-Mexico Border Public Health Association, Hermosillo, Sonora, Mex., April 4-8, 1960. Mr. Frank J. Von Zuben, Jr., Austin, Pres.; Dr. Jorge Román, 243 United States Court House, El Paso, Secy.

Texas Air-Medics Association, Fort Worth, April 9-11, 1960. Dr. W. W. Sumner, Fort Worth, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Public Health Physicians, Fort Worth, April 10, 1960. Dr. Fred K. Laurentz, Houston, Pres.; Dr. B. M. Primer, 2708 Rio Grande, Austin, Secy.

Texas Chapter, American College of Chest Physicians, Fort Worth, April 10, 1960. Dr. L. M. Shefts, San Antonio, Pres.; Dr. John W. Middleton, 900 Strand, Galveston, Secy.

Texas Chapter, American Academy of Pediatrics, Fort Worth, April 11, 1960. Dr. J. T. Bennett, El Paso, Pres.; Dr. W. W. Kelton, 108 West 30th, Austin, Secy.

Texas Dermatological Society, Fort Worth, April 11, 1960. Dr. Edmund N. Walsh, Fort Worth, Pres.; Dr. D. Shelton Blair, 1609 Medical Arts Building, Dallas, Secy.

Texas Diabetes Association, Fort Worth, April 10, 1960. Dr. Ralph Greenlee, Midland, Pres.; Dr. Warren W. Moorman, 901 W. Leuda, Fort Worth, Secy.

Texas Industrial Medical Association, Fort Worth, April 10, 1960. Dr. Max E. Johnson, San Antonio, Pres.; Dr. J. G. Burdick, P. O. Box 472, Pasadena, Secy.

Texas Neuropsychiatric Association, Fort Worth, April 10, 1960. Dr. Hamilton Ford, Galveston, Pres.; Dr. E. Ivan Bruce, 1014 Strand, Galveston, Secy.

Texas Ophthalmological Association, Fort Worth, April 11-12, 1960. Dr. Max Baldridge, Texarkana, Pres.; Dr. James H. Scruggs, 2223 Austin Ave., Waco, Secy.

Texas Orthopedic Association, Fort Worth, April 11, 1960. Dr. David M. Cameron, El Paso, Pres.; Dr. Margaret Watkins, 3503 Fairmount, Dallas, Secy.

Texas Otolaryngological Association, Fort Worth, April 11, 1960. Dr. Herbert H. Harris, Houston, Pres.; Dr. Louis E. Adin, 3707 Gaston, Dallas, Secy.

Texas Physical Medicine and Rehabilitation Society, Fort Worth, April 10, 1960. Dr. Edward M. Krusen, Dallas, Pres.; Dr. Oscar Selke, Medical Professional Building, Houston, Secy.

Texas Society of Anesthesiologists, Fort Worth, April 10, 1960. Dr. David O. Johnson, Austin, Pres.; Dr. M. T. Jenkins, Parkland Hospital, Dallas, Secy.

Texas Society of Athletic Team Physicians, Fort Worth, April 9, 1960. Dr. W. Harry Ledbetter, Wichita Falls, Pres.; Dr. Jack Brannon, 2715 Fannin, Houston, Secy.

Texas Society of Gastroenterologists and Proctologists, Fort Worth, April 10, 1960. Dr. Marcel Patterson, Galveston, Pres.; Dr. A. C. Broders, Jr., Scott and White Clinic, Temple, Secy.

Texas Society of Pathologists, Inc., Fort Worth, April 11, 1960. Dr. O. J. Wollenman, Jr., Fort Worth, Pres.; Dr. Vernie A. Stembridge, Parkland Hospital, Dallas, Secy.

Texas Society of Plastic Surgeons, Fort Worth, April 9, 1960. Dr. Willard Schuessler, El Paso, Pres.; Dr. Raymond Brauer, 6615 Travis, Houston, Secy.

Texas Society on Aging, Fort Worth, April 13, 1960. Dr. Ernest W. Keil, Temple, Pres.; Mrs. William B. Ruggles, 3701 Stratford, Dallas, Secy.-Treas.

Texas Surgical Society, Fort Worth, April 3-5, 1960. Dr. Robert Wilson Crosthwait, Waco, Pres.; Dr. G. V. Brindley, Jr., Scott and White Clinic, Temple, Secy.

Texas Traumatic Surgical Society, Fort Worth, April 10, 1960. Dr. W. D. Marrs, Fort Worth, Pres.; Dr. W. E. Crump, 1300 8th St., Wichita Falls, Secy.

Third District Society, Lubbock, April 2, 1960. Dr. Grady M. Wallace, Lubbock, Pres.; Dr. H. Fred Johnson, 2308 W. Eighth, Amarillo, Secy.

Seventh District Society, April, 1960. Dr. Robert N. Snider, Austin, Pres.; Dr. Richard Lucas, 502 W. 13, Austin, Secy.

Texas State Board of Examiners in Basic Sciences, Austin, Houston, Galveston and Dallas, April 8-9, 1960. Henry B. Hardt, Ph.D., Fort Worth, Pres.; Mrs. Betty J. Anderson, Chief Clerk, State Office Bldg., 201 E. 14th St.

MAY

American Association for Thoracic Surgery, Miami Beach, May 11-13, 1960. Dr. William E. Adams, Chicago, Pres.; Dr. Hiram T. Langston, 7730 Corondelet Ave., St. Louis 5, Secy.

American Association of Genito-Urinary Surgeons, Dearborn, Mich., May 11-13, 1960. Dr. Reed M. Nesbitt, Ann Arbor, Mich., Pres.; Dr. W. J. Engel, 2020 E. 93rd St., Cleveland 6, Secy.

American Association of Plastic Surgeons, Milwaukee, May 17-20, 1960. Dr. Lyndon A. Peer, New Jersey, Pres.; Dr. Thomas D. Cronin, 6615 Travis St., Houston 25, Secy.

American Gynecological Society, Williamsburg, Va., May 30-June 1, 1960. Dr. Karl H. Martzloff, Portland, Pres.; Dr. A. A. Marchetti, 3800 Reservoir Rd. N.W., Washington 7, D. C., Secy.

American Ophthalmological Society, Colorado Springs, May 16-18, 1960. Dr. A. B. Reese, New York, Pres.; Dr. M. C. Wheeler, 30 W. 59th, New York 19, Secy.

American Orthopaedic Association, Hot Springs, Va., May 30-June 2, 1960. Dr. John Royal Moore, Philadelphia, Pres.; Dr. Lee Ramsay Straub, 535 East 70th St., New York 21, Secy.

American Pediatric Society, Swampscott, Mass., May 5-6, 1960. Dr. Samuel Z. Levine, New York, Pres.; Dr. A. C. McGuinness, Room 1036, 2800 Quebec St., N.W., Washington 8, D. C., Secy.

American Psychiatric Association, Atlantic City, N. J., May 9-13, 1960. Dr. William Malamud, New York, Pres.; Dr. C. H. Hardin Branch, 156 Westminister Ave., Salt Lake City, Secy.

American Urological Association, Chicago, May 16-19, 1960. Dr. William M. Coppridge, Durham, N. C., Pres.; Mr. William P. Didusch, 1120 N. Charles St., Baltimore 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Rome, Italy, May 15-18, 1960. Dr. Henry Meyerding, Rochester, Minn., Pres.; Dr. Ross T. McIntire, 1516 Lake Shore Dr., Chicago, Executive Director.

National Tuberculosis Association, Los Angeles, May 15-20, 1960. Dr. H. McLeod Riggins, New York, Pres.; Mrs. Wallace B. White, 651 Marlborough Rd., Brooklyn, Secy.

Texas Division, American Cancer Society, Austin, May 4, 1960. Dr. David A. Todd, San Antonio, Pres.; Mr. Curt W. Reimann, 5014 Bull Creek Rd., Austin 3, Executive Director.

Texas Hospital Association, Dallas, May 10-12, 1960. Mr. F. S. Walters, Jr., Amarillo, Pres.; Mr. O. Ray Hurst, 2208 Main, Dallas, Executive Director.

Fourth District Society, San Angelo, May 7, 1960. Dr. S. Braswell Locker, Brownwood, Pres.; Dr. J. G. Bodenhamer, Mason, Secy.

National and Regional

American Academy of Allergy, Washington, D. C. Dr. Bram Rose, Montreal, Canada, Pres.; Dr. Joseph Noah, 100 N. Euclid Ave., St. Louis 8, Mo., Secy.

American Academy of General Practice, Miami, April 17-20, 1961. Dr. John G. Walsh, Sacramento, Calif., Pres.; Mr. Mac F. Cahal, Volker Blvd. at Brookside, Kansas City 12, Executive Secy.

American College of Allergists, Dallas, March 12-17, 1961. Dr. Giles A. Koelsche, Rochester, Minn., Pres.; Mr. Eloi Bauers, 2160 Rand Tower, Minneapolis, Executive Vice-Pres.

American Academy of Dermatology and Syphilology, Chicago, Dec. 3-8, 1960. Dr. Francis W. Lynch, St. Paul, Minn., Pres.; Dr. Robert R. Kierland, Mayo Clinic, Rochester, Minn., Secy.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 9-14, 1960. Dr. John H. Dunnington, New York, Pres.; Dr. W. L. Benedict, 15 Second St. S.W., Rochester, Minn., Secy.

American Association for Maternal and Infant Health. Dr. M. Edward Davis, Chicago, Pres.; Mrs. Patricia Dorr, 116 S. Michigan Ave., Chicago 3, Executive Director.

American Association of Obstetricians and Gynecologists, Hot Springs, Va., Sept. 8-10, 1960. Dr. Robert A. Ross, Chapel Hill, N. C., Pres.; Dr. Clyde L. Randall, 216 Summer St., Buffalo 22, Secy.

American Cancer Society, New York, Oct. 26-27, 1960. Dr. Warren H. Cole, Chicago, Pres.; Mr. Granville Whittlesey, 521 West 57th St., New York 19, Secy.

American College of Chest Physicians, Miami Beach, Fla., June 8-12, 1960. Dr. Seymour M. Farber, San Francisco, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut, Chicago 11, Executive Director.

American College of Gastroenterology, Philadelphia, Oct. 23-29, 1960. Dr. Joseph Shaiken, Milwaukee, Pres.; Mr. Daniel Weiss, 33 West 60th, New York 23, Executive Director.

American College of Radiology, Atlantic City, Sept. 30-Oct. 1, 1960. Dr. Earl E. Barth, Chicago, Pres.; Mr. W. C. Stronach, 20 N. Wacker Dr., Chicago 6, Executive Director.

American College of Surgeons, San Francisco, Oct. 10-14, 1960. Dr. Owen H. Wangensteen, Minneapolis, Pres.; Dr. William E. Adams, 950 E. 59th St., Chicago, Secy.

American Congress of Physical Medicine and Rehabilitation, Washington, D.C., Aug. 21-26, 1960. Dr. F. J. Kottke, Minneapolis, Pres.; Dorothea C. Augustin, 30 N. Michigan Ave., Chicago 2, Executive Secy.

American Gastroenterological Association. Dr. H. Marvin Pollard, Ann Arbor, Pres.; Dr. Wade Volwiler, University of Washington School of Medicine, Seattle 5, Secy.

American Heart Association, St. Louis, Oct. 21-25, 1961. Dr. A. Carlton Ernstene, Cleveland, Pres.; Mr. William F. McGlone, 44 E. 23rd, New York 10, Secy.

American Hospital Association, San Francisco, Aug. 29-Sept. 1, 1960. Dr. Russell A. Nelson, Baltimore, Md., Pres.; Dr. Edwin L. Crosby, 18 E. Division Street, Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society. Dr. Theodore E. Walsh, St. Louis, Pres.; Dr. C. S. Nash, 708 Medical Arts Bldg., Rochester, N. Y., Secy.

American Neurological Association, Boston, June 13-15, 1960. Dr. Derek Denny-Brown, Boston, Pres.; Dr. Melvin D. Yahr, New York Neurological Institute, 710 W. 168th Street, New York 32, Secy.

American Public Health Association, San Francisco, Oct. 31-Nov. 4, 1960. Dr. Malcolm H. Merrill, Berkeley, Calif., Pres.; Dr. Berwyn F. Mattison, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, New York, Oct. 2-7, 1960. Dr. J. Earl Remlinger, Jr., Wilmette, Ill., Pres.; Dr. Robert L. Patterson, 612 Bershire Drive, Pittsburgh 15, Secy.

American Society of Clinical Pathologists, Chicago, Sept. 24-Oct. 2, 1960. Dr. John J. Clemmer, Albany, Pres.; Mr. Claude E. Wells, 445 Lake Shore Drive, Chicago 11, Executive Secy.

Association of American Physicians and Surgeons, St. Louis, Sept. 29-Oct. 1, 1960. Dr. Louis Wegryn, Elizabeth, N. J., Pres.; Mr. Harry E. Northam, 185 N. Wabash Ave., Chicago 1, Executive Director.

Radiological Society of North America, Cincinnati, Ohio, Dec. 4-9, 1960. Dr. Lawrence L. Robbins, Boston, Pres.; Dr. Donald S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

South Central Association of Blood Banks. Dr. John B. Alsever, Phoenix, Pres.; L. Ruth Guy, Ph.D., Room 1101, Stoneleigh Hotel, Dallas, Secy.

Southern Medical Association, St. Louis, Oct. 31-Nov. 3, 1960. Dr. Edwin H. Lawson, New Orleans, Pres.; Mr. Robert F. Butts, 2601 Highland Ave., Birmingham 5, Ala., Executive Secy.

Southern Psychiatric Association, Virginia Beach, Va., Oct. 2-4, 1960. Dr. David A. Wilson, Charlottesville, Va., Pres.; Dr. Richard Proctor, Winston-Salem, N. C., Secy.

Southern Surgical Association, Boca Raton, Fla., Dec. 6-8, 1960. Dr. Francis Massie, Pres.; Dr. John D. Martin, Jr., Emory University, Ga., Secy.

Southwest Regional Cancer Conference, Fort Worth, Oct. 23, 1960. Dr. Robb Rutledge, Fort Worth, Chm.; Mrs. Ira Frances Ball, Westchester House, Fort Worth, Secy.

Southwestern Medical Association, El Paso, Oct. 20-22, 1960. Dr. R. L. Deter, El Paso, Pres.; Dr. Merle Thomas, 1501 Arizona Building, El Paso, Secy.

Southwestern Society of Nuclear Medicine, San Antonio. Dr. Peter E. Russo, Oklahoma City, Pres.; Dr. J. R. Maxfield, Jr., 2711 Oak Lawn Avenue, Dallas, Secy.

Southwestern Surgical Congress, Fort Smith, Ark. Dr. Fred H. Krock, Fort Smith, Ark., Pres.; Mary O'Leary, 813 Medical Arts Bldg., Oklahoma City, Exec. Secy.

Tri-State Medical Assembly, Louisiana, Sept. 14-15, 1960. Dr. R. B. Langford, Shreveport, Pres.; Dr. J. W. Wilson, Jr., 940 Margaret Place, Shreveport, Secy.

State

Private Clinics and Hospitals, Dallas, December, 1960. Dr. Vance Terrell, Stephenville, Pres.; Mr. B. J. Warren, Deaton Hospital, Galena Park, Secy.

Texas Academy of General Practice, Dallas, Oct. 3-5, 1960. Dr. E. Sinks McLarty, Galveston, Pres.; Mr. Donald C. Jackson, 1905 N. Lamar, Austin, Executive Secy.

Texas Academy of Internal Medicine. Dr. Merton M. Minter, San Antonio, Pres.; Dr. Hugo T. Engelhardt, 1216 Main, Houston, Secy. Meetings restricted to members.

Texas Association for Mental Health, Galveston, 1961. Mr. William R. Ransone, Dallas, Pres.; Mrs. Lawrence Marcus, 3525 Arrowhead Drive, Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, Feb. 10-11, 1961. Dr. Oran V. Prejean, Dallas, Pres.; Dr. Hugh W. Savage, 815 Fifth Ave., Fort Worth, Secy.

Texas Club of Internists. Dr. W. W. Bondurant, Jr., San Antonio, Pres.; Dr. T. Haynes Harvill, Medical Arts Building, Dallas 1, Secy.

Texas Heart Association. Dr. Robert E. Leslie, El Campo, Pres.; Mr. Ernest T. Guy, 404 Jesse H. Jones Library Building, Houston 25, Executive Director.

Texas Pediatric Society, October, 1960, Dallas. Dr. Byron York, Houston, Pres.; Dr. C. E. Gilmore, 811 Bonham, Paris, Secy.

Texas Proctologic Society, Houston, February, 1961. Dr. J. Wade Harris, Houston, Pres.; Dr. H. Gray Carter, 915 St. Joseph St., Dallas, Secy.

Texas Public Health Association, Fort Worth, March 5-8, 1961. Mrs. Maggie Belle Davis, Corpus Christi, Pres.; Mr. Joseph N. Murphy, Jr., Box 4012, Austin 51, Executive Secy.

Texas Radiological Society, Fort Worth, Jan. 20-21, 1961. Dr. Delphin von Briesen, El Paso, Pres.; Dr. R. P. O'Bannon, 1216 Pennsylvania, Fort Worth, Secy.

Texas Rheumatism Association, Dallas, Dec. 9, 1960. Dr. Howard C. Coggeshall, Dallas, Pres.; Dr. J. Morris Horn, 3707 Gaston, Dallas, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 2-3, 1960. Dr. Lyle J. Logue, Houston, Pres.; Dr. Oliver Suehs, 14 Medical Arts Square, Austin, Secy.

Texas Tuberculosis Association, Corpus Christi, March 16-18, 1961. Dr. J. Edward Johnson, Pres.; Miss Pansy Nichols, P. O. Box 6158, Austin 21, Executive Director.

Texas Urological Society, Wichita Falls, January 21-22, 1961. Dr. Joseph Mitchell, Dallas, Pres.; Dr. O. C. Berg, 1300 8th St., Wichita Falls, Secy.

District

First District Society. Dr. Russell Holt, El Paso, Pres.; Dr. Gordon L. Black, 1501 Arizona St., El Paso, Secy.

Second District Society, Snyder, 1961. Dr. M. J. Loring, Midland, Pres.; W. S. Parks, Jr., 2009 W. Wall, Midland, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July 8-9, 1960. Dr. John W. Chriss, Pres.; Dr. James Gabbard, 1001 Louisiana, Corpus Christi, Secy.

Eighth District Society, Corpus Christi, July 8-9, 1960. Dr. M. Warren Hardwick, Angleton, Pres.; Dr. J. L. Coleman, Box 3346, Victoria, Secy.

Ninth District Society, Bellville, Spring, 1961. Dr. Irving M. Watson, Jr., Conroe; Dr. William E. Sharp, 721 E. Texas, Baytown, Secy.

Tenth District Society, September, 1960. Dr. J. W. McCall, Jr., Beaumont, Pres.; Dr. Irving M. Richman, 3280 Fannin St., Beaumont, Secy.

Eleventh District Society. Dr. Ben Wilson, Tyler, Pres.; Dr. Floyd Verheyden, 813 John St., Jacksonville, Secy.

Twelfth District Society, Marlin, January, 1961. Dr. Bernard Rosen, Corsicana, Pres.; Dr. R. L. Campbell, 205 S. 15th, Corsicana, Secy.

Thirteenth District Society, Fort Worth, Fall, 1960. Dr. William B. Allensworth, Mineral Wells, Pres.; Dr. R. D. Moreton, 1217 W. Cannon, Fort Worth, Secy.

Fifteenth District Society. Dr. Charles Wise, Naples, Pres.; Dr. George Bennett, 402 S. Bolivar, Marshall, Secy.

Clinics

Blackford Memorial Cancer Lectures, Denison, Nov. 11, 1960. Dr. Andrew Jackson, Denison, Chm.

Dallas Southern Clinical Society Conference, Dallas, March 20-22, 1961. Dr. Frank H. Kidd, Jr., Dallas, Pres.; Millard J. Heath, 433 Medical Arts Bldg., Dallas 1, Executive Officer.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 23-25, 1961. Dr. Max E. Johnson, San Antonio, Pres.; S. E. Cockrell, 202 W. French Place, San Antonio, Exec. Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 6-9, 1961. Dr. Maurice E. St. Martin, New Orleans, Pres.; Mrs. Irma B. Sherwood, 430 Tulane Ave., New Orleans 12, Executive Secy.

North Texas-Southern Oklahoma Fall Clinical Conference. Dr. Frank J. Lee, 1300 8th, Wichita Falls, Chm.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 24-26, 1960. Dr. Vernon D. Cushing, Oklahoma City, Pres.; Miss Alma F. O'Donnell, 503 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas, Houston, July 18-20, 1960. Dr. C. Alsworth Calhoun, Houston, Pres.; Mrs. W. H. Dahme, 412 Jesse H. Jones Library Bldg., Houston 25, Exec. Secy.

Board Examinations

Texas State Board of Medical Examiners, Fort Worth, June 20-22, 1960. Dr. M. H. Crabb, Fort Worth, Secy.; Mrs. Luanna Reddin, 1714 Medical Arts Bldg., Fort Worth, Assistant Secy.

MEDICOLEGAL NOTES

Doctors Concerned in Taking Blood Samples of the Intoxicated

There appears to be increasing concern by the physicians of this state as to their legal position when assisting law enforcement officers in obtaining blood samples from individuals, in the custody of these law enforcement officers, who are suspected of being intoxicated. From a legal standpoint, we are of the opinion that this concern by the physicians is certainly not without basis.

While we feel that normally physicians are glad to be of assistance to the state's various law enforcement officers, this one particular area does present certain legal problems which causes some reluctance on the physician's part to make his services available in obtaining these blood samples.

This concern by the physicians results from a realization that in Texas it has long been recognized that a physician can be held liable for operating upon or treating a patient without consent first being obtained. This was forcibly brought home in the case of *Moss vs. Rishworth* (Tex. Civ. App. 1913, 1920—159 SW 122 and 222 SW 225) where the following was held by the court:

> ". . . The law, as enunciated by the few courts which have passed thereon, is not as clear and satisfactory as it should be in cases of this character, but it seems to be reasonably established that a physician is liable for operating upon a patient unless he obtains the consent of the patient, *if competent,* and if not, of someone, who under the circumstances would be legally authorized to give the requisite consent. Of course consent may be presumed from circumstances, without direct proof, but there must be consent in every case, except in an emergency when to delay to obtain consent would endanger the life or health of the patient . . ." (159 SW 122)
>
> ". . . The authorities are unanimous in holding that a surgeon is liable for operating upon a patient, unless he obtains the consent of the patient, *if competent to give such consent,* or, if not, of someone who, under the circumstances, would be legally authorized to give the requisite consent . . . The parent was the only one who could legally give consent to perform it, and, if not given, the physician's act in performing it was a legal wrong. If performed without the consent of the parent, it would amount to a *technical assault for which the child could have recovered . . .*" (222 SW 225) [Emphasis added.]

This case readily demonstrates that failure of the physician to obtain consent from a patient prior to an operation or treatment, can subject the physician to a lawsuit based upon a technical assault upon the patient. Even more pertinent to the particular question at hand is the comment of the court in both opinions of the physician obtaining the consent of the patient, if the patient is ". . . *competent to give such consent . . .*" [Emphasis supplied.]

It is at this point that the obtaining of blood samples from individuals in the custody of law enforcement officers and who are suspected of being intoxicated presents certain legal problems. Consent of the individual, and likely in writing, will have been obtained, but what if the results established the fact that the individual is, in fact, intoxicated? This, in itself, would tend also to establish that such individual *was not competent to consent to the physician taking the blood sample.* Should the intoxication be sufficient to render the individual incompetent to understand the nature or effect of his acts, then conceivably the consent previously given may well be void and as a result the physician might be liable for a technical assault in obtaining the blood samples. It is for this reason that some physicians are reluctant to aid the law enforcement officers obtain these blood samples.

While to date, in Texas, a suit of this nature has never reached our appellate courts, and while we do not advocate discontinuing cooperation and assistance to law enforcement officers in cases of this nature, we do feel that the physicians should be aware of the dangers present. The ultimate solution to this problem, whereby the physician would be afforded protection and the officers would be able to readily obtain assistance in obtaining voluntary blood samples, might well be legislation similar to that being enacted in some states which would grant immunity to the physician when obtaining these blood samples at the request of law enforcement officers.

—PHILIP R. OVERTON, LL.B., Austin.

Medical Reports Are Basis For Social Security Disability Benefits

Primary basis for determining whether a worker meets social security requirements of disability is a medical report furnished by the attending physician, and reports from other physicians, hospitals, or clinics. Determination of disability rests with an administrative team including a physician.

A review of "How Social Security Medical Reports Are Used" is presented by Dr. William Roemmich of Baltimore in the December 19, 1959, issue of the *Journal of the American Medical Association.* His comments answer some

of the questions that arise among Texas physicians called on for reports in connection with social security claims. Additional information may be obtained from local social security representatives.

Effective since January, 1955, the law defines disability as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration," Dr. Roemmich indicates. Following are conditions which must be met:

1. The claimant's condition must be medically determinable—that is, it must be a condition that can be confirmed by medical examinations and tests.
2. The condition must be so severe that it prevents the person not only from carrying on his last or usual occupation but also from performing any substantial gainful activity.
3. The condition must have persisted for at least 6 months, despite therapy, and must be expected to continue indefinitely, or to result in death.
4. The condition must not be remediable through treatment that is safe and reasonable according to usually accepted standards of medical practice.
5. The claimant must have a record of work under social security. In this connection, his work record must include a definite number of calendar quarters of social security coverage.

When a patient applies for benefits at his nearest social security district office, he is given an explanatory letter and one or more copies of a medical report form to deliver to his attending physician or any other physician, clinic, hospital, institution, or agency in which he has been treated for his condition.

Furnished primarily for the convenience of the physician, Dr. Roemmich reminds, the medical report form should not prohibit the doctor from including sufficient information. A full clinical picture—history, physical, and supporting laboratory findings—of the patient's condition is needed, so that a reviewing physician may evaluate the diagnosis and the therapeutic possibilities as well as the patient's capacity for work. If possible, a physician should include a careful description of any limitations on the patient's ability to walk, sit, stand, bend, think, hear, see, and manipulate. Requested information may be furnished on a physician's own stationery in a narrative statement, instead of on the form.

Two persons—a nonmedical individual trained in disability evaluation and a doctor of medicine—compose the state agency's review team. Severity, duration, and remediability of the "medically determinable impairment" is the reviewing physician's primary responsibility. The applicant's ability to perform substantial gainful work (in the light of his education, training, work, history, and demonstrated vocational skills) is evaluated by the nonmedical member of the team.

Upon completion of the team's evaluation, the Bureau of Old-Age and Survivors Insurance reviews the state determinations for consistency and conformity to national policies. The bureau cannot reverse a state decision which is unfavorable to the applicant. Only through the appeals process can such a decision be reversed.

When a claimant believes the decision on his claim is incorrect, Dr. Roemmich states, he may ask for reconsideration, which calls for careful reexamination by the state agency and the bureau. If he is still dissatisfied, he may request an audience before a hearing examiner of the Social Security Administration. Finally, a claimant may appeal to the federal court for review.

Responsibility for actually determining that a patient suffers a disability is not placed on the physician's shoulders. Responsibility is placed, according to the law, upon the state and federal administrative agencies. Nevertheless, the attending examining doctor's opinion is highly regarded and carefully considered.

Vocational rehabilitation—restoring as many disabled persons as possible to the labor force—is the goal of the state agency, which considers all disability claimants for possible services by the state vocational rehabilitation agency. When completing the medical report, the doctor may want to keep this goal in mind—since he may have knowledge which would assist the rehabilitation counselor in planning and providing services for the patient.

Medical reports are an integral part of the claim file and each report is safeguarded by the same legal restrictions which govern the confidential nature of all social security records, Dr. Roemmich points out. Reports furnished by attending physicians are of paramount importance in the successful administration of the social security disability program.

DRUG NOTES

Cancer Chemotherapy Progresses Although Successes Are Few

Outstanding reviews and original papers discussing recent developments in cancer chemotherapy have prompted this brief resumé that will outline the most significant potential antineoplastic agents.

In spite of the fact that a determined battle is under way to conquer cancer, successes so far are few. (The year 1959 has witnessed the investment of up to $100,000,000 into these efforts.) The fact that successes have been rather modest has not discouraged researchers, and a vast search for antineoplastic drugs continues. Although no absolute cures have been elucidated, research efforts by chemists have turned up many chemicals that have shown enough promise to stimulate clinical experimentation. Approximately 20 products are currently in general clinical use, and about 100 others in preliminary clinical testing stages. Most of these compounds fall into the following classifications based on their possible mechanism of action:

1. Alkylating agents.
2. Antimetabolites.
3. Hormones and other steroids.
4. Antibiotics and natural products.

Alkylating Agents.—This class is exemplified by the general group or organic compounds known as "nitrogen mustards." A case in point may be cited by making reference to a relatively new product discussed previously in this column (Drug Notes, Texas J. Med. 56:123 [Feb.] 1960), Cytoxan, Meade-Johnson. These alkylating agents are polyfunctional cytotoxic compounds which are able to replace hydrogen with alkyl groups in biologically essential materials, thus giving rise to inhibition of the malignant cells.

The original nitrogen mustards are quite toxic, hence, exhibit a low therapeutic index. In spite of this general property, relatively safe nitrogen mustards have been synthesized. Effective drugs occur with nitrogen mustards containing amino acid residues as exemplified with the case of chloroambucil (Leukeran, Burroughs Wellcome). The search for effective and safe nitrogen mustards continues. Recently, a phenylalanine nitrogen mustard was developed, and is currently available as melfalan (Alkeran, Burroughs Wellcome) and called Sarcolysm in Russia. Effective

cytotoxic agents also have been synthesized by replacing the chlorine atoms of the nitrogen mustard molecule with sulfonic ester radicals leading to the methanesulfonate esters, such as Myleran (Burroughs Wellcome). Myleran is used currently with a certain degree of effectiveness against some forms of leukemia.

Antimetabolites.—Antimetabolites are exogenous compounds possessing closely related structures to certain absolutely essential cell constituents. Therefore, they function on the basis of competitive inhibition of enzyme systems that depend on these certain essential cell constituents, and give rise to an inhibition of the growth processes of the malignant cells. Again in this case a new product recently mentioned in this column (Drug Notes, Texas J. Med. 56:50 [Jan.] 1960), may be cited as a classical example, 5-Fluorouracil, an antipyrimidine.

An additional illustration may be mentioned with the case of one of the pioneer antimetabolites, Aminopterin, an antifolic acid agent, which in spite of the toxicity has shown a pronounced degree of effectiveness against leukemia. This observation led to the synthesis of another folic acid antagonist, Methotrexate (Lederle), which is reported to be just as active as Aminopterin, but less toxic.

Although these developments indicate that progress in this field has been outstanding, a comprehensive review of the field of antimetabolites reveals that many compounds have been synthesized as potential anticancer agents, but few have proven to be useful. Furthermore, it becomes readily obvious that none of these new compounds are really ideal; consequently, the search continues also in this phase of cancer chemotherapy research.

Hormones and Miscellaneous Steroids.—A certain degree of success has been reported in the treatment of cancer of the prostate with estrogenic steroids. Androgenic substances also have exhibited a certain degree of effectiveness in the treatment of cancers of the breast. These cases are complicated with the usual side effects exhibited by these hormones, virilization and feminization. Research in this field is directed towards the search of new estrogenic compounds that will exhibit a minimum of side effects and high anticarcinogenic activity.

Certain adrenocorticometric steroids also have been investigated as anticancer agents. It is well known that prednisone and prednisolone have been used in the treatment of acute leukemia. Currently, the fluorosteroids are under investigation.

Antibiotics.—The fruitfulness of antibiotic research in the field of bacterial chemotherapy has served as a stimulation that has led to intensive investigations for fermentation products with anticancer activity. Although a multitude of these natural products have been screened, only relatively few have reached clinical evaluation stages.

Azaserine (L-serine-diazoacetate), well known as a glutamine antagonist, is known to exert antineoplastic action by virtue of its capacity to inhibit the use of glutamine in the synthesis of the biologically essential purines. This compound is classified as an antibiotic, because it is derived from culture broths of Streptomyces. Although this compound has shown remarkably carcinostatic potency, it has had little success clinically and is known to produce cumulative toxicity. D.O.N. (6-diazo-5-oxo-L-norleucine) is also an antiglutamine that has been studied as a potential antineoplastic agent.

Puromycin also has received some attention as an anticancer agent since it has shown satisfactory effects in certain malignancies. These effects are essentially temporary regressions. The puromycin molecule contains a purine moiety in its structure, and purines are capable of reversing its inhibitory effects. Hence, it is believed that this antibiotic actually functions as an antipurine.

Certain Japanese clinicians have reported success with Mitomycin-C, derived from Streptomyces caespitosus, but American clinicians have reported untoward side effects. In view of the high anticancer activity and the numerous side effects, researchers have directed their efforts towards the synthesis of derivatives. It is hoped that some of these derivatives will retain the activity and exhibit a minimum of side effects.

Actidione-D is a rather new antibiotic that has undergone extensive study in Russia, but complete and comprehensive clinical data are not available.

There are many other antibiotics that are currently under investigation, for example, Streptovitacin-A, piscofuranine, and Actinomycin-D.

Miscellaneous Natural Products.—Colchicine, the well known alkaloid, has been studied extensively. Most of the biological properties of this alkaloid have been described, including its carcinostatic activity. In view of this property, as well as its use in the treatment of gout, it has created a lot of interest. This interest, together with theoretical interests of researchers, has led to the successful synthesis of this complex alkaloid by Dr. van Tamalen, research chemist of the University of Wisconsin. Therefore, from a biological standpoint, interest in this compound is at an all time high and researchers continue to study this alkaloid and its derivatives. Now that its synthesis has been reported, it would probably be advisable to screen these intermediates that led to colchicine.

Other natural products that have shown carcinostatic activity include podophyllin and podophyllotoxin.

This resumé comprises an outline of the most significant types of antineoplastic agents which are used or have been studied for the treatment of malignant disease. These agents owe their antineoplastic activity to their ability to inhibit the growth of malignant cells. Logically, the ideal anticancer agent would be one that selectively inhibits the growth of malignant cells without affecting the normal cells. Unfortunately, there are no agents that exhibit this high degree of selective affinity for malignant cells. Nevertheless, the search continues for such an ideal antineoplastic agent.

—HERBERT SCHWARTZ, M.S., and
JAIME N. DELGADO, M.S., Austin.

EDUCATION

Postgraduate Courses

Early Detection and Prevention of Disease, Philadelphia, May 9-13.—The University of Pennsylvania School of Medicine's Department of Public Health and Preventive Medicine and the American College of Physicians will present Postgraduate Course 4 on early detection and prevention of disease from May 9 to 13. Special emphasis will be placed upon detection of disease before development of readily recognized signs and symptoms. Included in the course will be an up-to-date review of the practical experience of clinics and individuals who have been actively engaged in efforts to detect asymptomatic disease and to prevent its progress and complications. Further information may be obtained by writing Executive Offices, 4200 Pine Street, Philadelphia 4. Fees for members are $60 and for nonmembers, $80.

Current Research in Cardiovascular Disease, Philadelphia, May 16-20.—The American College of Physicians will present its Postgraduate Course 5 on "Current Research in Cardiovascular Disease" from May 16 to 20 at the National Heart Institute, Bethesda 14, Md. Designed to give the internist a discussion of many facets of cardiovascular

disease currently under investigation, the course will not attempt to cover all of the basic studies nor to cover the entire field of cardiovascular disease. The research program of the Heart Institute will serve as a basis for presentations. Two hours each day will be devoted to a presentation of vector methods of electrocardiographic interpretation by Dr. Robert P. Grant of the Heart Institute and his staff. Further information may be obtained by writing the Executive Offices, 4200 Pine Street, Philadelphia 4. Fees are $60 for members and $80 for nonmembers.

Pediatric Allergy, Austin, May 22.—The University of Texas Postgraduate School of Medicine will sponsor a program on pediatric allergy from 9 a.m. until 5 p.m., Sunday, May 22, in the Texas Medical Association Building, 1801 N. Lamar Boulevard, Austin. A team of experts will speak on each facet of this subject; local arrangements are being made by Dr. Thomas R. McElhenney. The program is approved by the Texas Academy of General Practice for 6 hours of Category I credit. Further information may be requested from the Office of the Dean, University of Texas Postgraduate School of Medicine, 410 Jesse Jones Library Building, Texas Medical Center, Houston 25.

The Hypertensive Diseases: Diagnostic and Therapeutic Procedure in Essential, Adrenal, and Renal Hypertension, May 23-26.—The American College of Physicians is presenting its Postgraduate Course 6 on hypertensive diseases May 23-26 at the Massachusetts Memorial Hospitals in Boston. To be considered in the course are problems of hypertension from the moment of its recognition in a patient by a physician, through its proper clinical classification made with the help of various diagnostic and prognostic procedures, and the selection of therapy including long term management by all available means, both medical and surgical. Included in the course will be current concepts of the basic pathologic physiology of all the hypertensive disorders. Registration fees are $60 for members and $80 for nonmembers. Further information may be obtained from the executive offices, 4200 Pine Street, Philadelphia 4.

Theory and Practical Fitting of Contact Lenses, Houston, May 23-26.—The University of Texas Postgraduate School of Medicine will hold this course for a limited class of 20 physicians certified by the American Board of Ophthalmology. Instructors will be ophthalmologists who are experienced in the fitting of contact lenses. Those completing the course will be proficient in all phases of contact lense fitting and adjusting. Further information is available from the Office of the Dean, University of Texas Postgraduate School of Medicine, 410 Jesse Jones Library Building, Texas Medical Center, Houston 25.

Physical Medicine and Rehabilitation in Neuromuscular and Medical Conditions, Denver, June 1-3.—This course, slated for the University of Colorado Medical Center, is sponsored by its Department of Physical Medicine and Rehabilitation, Office of Postgraduate Medical Education. It is supported by the Office of Vocational Rehabilitation, United States Department of Health, Education, and Welfare; Sister Elizabeth Kenny Foundation; United Cerebral Palsy Association of Colorado; and United Cerebral Palsy Association of Denver. Main topics discussed in the 2½ day course will be cerebral palsy, muscular dystrophy, multiple sclerosis, and geriatrics. The course will be approved for Category I credit by the American Academy of General Practice for the total number of hours attended by the individual registrant. Physical and occupational therapists may attend, as well as physicians. Full tuition is $35 and should accompany the application; this includes a $5 registration fee which is nonrefundable. Application forms are available from the Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20.

Physical Medicine and Rehabilitation in Neuromuscular and Medical Conditions, Denver, June 1-3.—A course on physical medicine and rehabilitation in neuromuscular and medical conditions will be offered by the University of Colorado Medical Center at Denver from June 1 to 3. Further information may be obtained by writing the Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20.

Diseases of the Chest, June 6-24.—Trudeau School of Tuberculosis and Other Pulmonary Diseases will hold its forty-fifth session from June 6 to 24 in Saranac Lake, N. Y., Miss Ruth S. West, secretary, has announced. To be considered during the annual postgraduate course are diseases of the chest, with tuberculosis receiving the greatest attention. In addition, subjects to be covered include silicosis, pulmonary fibrosis, emphysema, fungous infection, sarcoidosis, pneumonias, and intrathoracic tumors. Enrollment for the course is limited and application should be made early. Inquiries should be addressed to the secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 500, Saranac Lake, N. Y.

Clinical Hematology, Denver, June 20-25.—The University of Colorado Medical Center at Denver will present a course on clinical hematology from June 20 to 25. Information on the course, which will be limited to 12 registrants, may be obtained from the Office of Postgraduate Medical Education at the University of Colorado Medical Center, 4200 East Ninth Avenue, Denver.

Internal Medicine, Indianapolis, June 20-24.—Postgraduate Course 7 on internal medicine will be presented by the American College of Physicians at the Indiana University School of Medicine, Indianapolis, from June 20 to 24. Selected subjects in the field of internal medicine will be studied. Emphasis will be placed on pathological physiology and mechanisms of disease. Information on the course may be obtained from the Executive Offices, 4200 Pine Street, Philadelphia 4. Fees are $60 for members and $80 for nonmembers.

Obstetrics and Gynecology, Denver, June 27-29.—A course on obstetrics and gynecology will be offered by the University of Colorado Medical Center at Denver from June 27 to 29. Further information can be received by writing the Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20.

Research, Clinical Fellowships Offered by National Foundation

Research and clinical fellowships are being offered currently by the National Foundation, New York, for postdoctoral work.

Candidates who are preparing for careers in scientific research and/or academic medicine may apply for the fellowships, which provide research training in medicine and the related biological and physical sciences through participation in a specific project.

To qualify for the fellowship, applicants must hold an M.D., Ph.D. or equivalent degree, be United States citizens, and have sound health. The program will include full time study and investigation in the research program of the fellow's choice and will last for 1 or 2 years, occasionally longer.

Financial stipends are at three basic levels: $4,500, $5,460, and $6,420 per year. Maximum stipend is $8,000 per year, plus an amount not exceeding $600 for transportation for study abroad.

Applications may be made at any time during the year

and selection of candidates will be by the Research Fellowship Committee, which meets approximately 2 to 3 months following the closing dates of August 1, November 1, and February 1.

Clinical fellowships will be offered in arthritis and related diseases in orthopedics, in preventive medicine, and in rehabilitation. General requirements are basically the same as for research fellowships. Further information may be obtained from the National Foundation, 800 Second Avenue, New York 17.

Mexico City to be Site of Course On Reconstructive Nasal Surgery

Mexico City will be host July 4-15 for an international course on "The Fundamentals of Reconstructive Surgery of the External Nasal Pyramid and the Nasal Septum." The course will be presented under the auspices of the Escuela Nacional de Medicina e Division del Doctorado, and with the cooperation of the American Rhinologic Society.

Guest professor will be Dr. Maurice H. Cottle, professor of otolaryngology at the Chicago Medical School and founder of the American Rhinologic Society. Dr. Cottle will be assisted by a faculty of specialists from the United States and Mexico. Lectures are to be presented simultaneously in English and Spanish.

For further information on the course and application forms, interested diplomates of the American Board of Otolaryngology (or those with equivalent status) may write to Dr. Robert M. Hansen, secretary of the American Rhinologic Society, 1735 North Wheeler Avenue, Portland 12, Oregon.

Medical Students' Day Program Scheduled for Baylor

The seventh annual Medical Students' Day at Baylor University College of Medicine will be held on the afternoon of Thursday, April 28, 1960, at Baylor Auditorium in Houston. The program, presented by the Texas Medical Association and the Harris County Medical Society, will be given before the senior class. Officers of the Harris County Medical Society and department heads of the medical school also have been invited to attend.

In the evening, the seniors and their wives will be the guests of the Association for dinner at the Doctor's Club. They will hear Dr. May Owen, President of the Texas Medical Association, give the dinner address.

Similar programs are held each year for the seniors at the three medical schools in Texas.

MEDICAL MEETINGS

General Practitioners Elect Murphy

Dr. James D. Murphy of Fort Worth was elected vice-president and chairman of the board of the American Academy of General Practice at the organization's meeting, March 20-24, in Philadelphia.

A total of 7,506 attended the meeting at which the membership standards were raised to require from 1 to 2 years' graduate training following medical school.

The next meeting of the academy will be held in Miami, April 13-20, 1961.

Abilene Physicians, Ministers Attend Joint Meetings

Togetherness, a cliche initiated by a national magazine and scorned by many "thinkers," now has real meaning for a group of Abilene doctors.

Approaching the theory from a new angle, staff members of Hendrick Memorial Hospital in Abilene invited ministers of their city to a joint meeting of physicians and pastors. Purpose of the togetherness move was, simply, to enable the two professions to become better acquainted and to understand problems which jointly concern them—people.

Dr. Milford O. Rouse, Dallas, past president of the Texas Medical Association, was speaker for the first workshop and dinner meeting on February 2. Declaring that a "minister can be a doctor's strongest ally," Dr. Rouse pointed out that physicians meet ministers in the corridors of the hospital and often at the bedsides of patients. They are realizing increasingly, he added, that it is of advantage to the patient for the clergyman to be an active member of the health team.

Dr. Travis Smith, one of the chief organizers of the joint meeting, has called the meeting "the most important piece of public relations that the doctors of this community have carried out," and he declared that it "is going to pay great dividends insofar as the care of patients is concerned."

At least three incidents paved the way towards the meeting, Dr. Smith recalls. First was the hiring about 3 years ago of Charles L. Myers as Hendrick Hospital chaplain. Mr. Myers, Dr. Smith stated, has gradually obtained the trust of every physician on the staff. Prior to the banquet meeting, Mr. Myers had held a 1-day conference for ministers at the hospital, at which talks were made by staff members.

Second, Dr. Smith relates, he was inspired to organize such a meeting after a committee of his own church began studying the problem of religion and health.

"I have been very interested in the findings of this committee," he said, "and they have shown me that there is an extremely important avenue of service to patients that was being neglected for many years. With all of these things rumbling around in the back of my mind, I had the final inspiration given to me when one of the local ministers and I were riding home from a funeral, and he was commenting about how he appreciated the work of Chaplain Myers, and how he wished that the doctors and ministers of Abilene could become better acquainted so that the ministers could help the doctors and the doctors, in turn, could help the ministers."

Chaplain Myers and Dr. Smith then began to plan the joint meeting.

Topic of the workshop for ministers held during the day was "guilt." The program was designed especially to help the minister in his counseling work. Chaplain Myers directed the workshop and, in addition, is offering a series of 12-week courses in clinical pastoral training.

At the evening meeting and banquet, attended by nearly 100 physicians and ministers, Dr. Smith and Dr. Jack A. Crow, president of the Hendrick staff, presided. Dr. Crow's father, a retired Methodist minister, was among the pastors present.

Enthusiasm following the meeting has been high, Dr. Smith reports, and he advocates meetings of the type for other cities.

Texas Surgical Society Meets in Fort Worth

The Texas Surgical Society met April 3, 4, and 5 in Fort Worth for its semiannual session.

Guest speaker was Dr. Alfred S. Frosbese, associate professor of surgery in the University of Pennsylvania Graduate School of Medicine and associate surgeon of the University of Pennsylvania Graduate Hospital. His initial topic was "Surgical Treatment of Hiatus Hernia."

Other topics discussed and their speakers: "Diverticula of the Duodenum," Dr. Elbert H. Caldwell, Tyler; "Colostomy Management," Dr. O. P. Griffin, Fort Worth; "Local Excision of Selected, Early, Small, Malignant Lesions of the Rectum," Dr. G. V. Brindley, Sr., Temple; "Radioiodine Fat Absorption Studies in Patients with Biliary Disease," Dr. A. O. Singleton, Jr., and Dr. John B. Lynch, Galveston; "Preoperative Irradiation and Resection in the Treatment of the Superior Sulcus Tumor," Dr. Robert R. Shaw, and Dr. Donald L. Paulson, Dallas.

Topics delivered during the April 4 afternoon session: "Experiences with Perfusion in the Treatment of Cancer," Dr. E. C. White, and Dr. John S. Stehlin, Jr., Houston; "The Combined Management of Necrotizing Pneumonia," Col. William W. Nichol, and Lt. Col. Thomas H. Hewlett, Fort Sam Houston; "Vena Caval Filter for Pulmonary Infarctions," Dr. John Paul North, Dallas; "The Intraperitoneal Repair of Incisional Hernia with Marlex Mesh," Dr. Francis C. Usher, Houston; "Major Surgery in Hemophiliac Patient," Dr. J. Harold Cheek, Dr. Joseph Hill, and Dr. Arturo Aguillon, Dallas; "Further Evidence Supporting the Removal of Benign Thyroid Nodules," Dr. J. Allen Chamberlin and Dr. Herbert C. Allen, Jr., Houston.

Topics delivered April 5: "Parathyroid Intoxication," Dr. Edwin M. Sykes, Jr., San Antonio; "Embolization of the Superior Mesenteric Artery," Dr. John F. Lindsey, Fort Worth; "Injuries of the Bladder and Urethra," Dr. E. O. Bradfield, Temple, and Dr. A. R. Tormey, Madison, Wis.; "Trends in the Management of Colonic Diverticulitis," Dr. Frosbese; "Muscle Origin Release Operation for Congenital Elevation of the Scapula," Dr. Joe Woodward, Waco; and "Case Report of Villous Papillomas of the Colon and Rectum with Electrolyte Imbalance," Dr. Fred B. Aurin and Dr. John Marietta, Fort Worth.

Banquet speaker on April 4 was R. P. Dupree, Jr., Fort Worth, whose topic was "New York Resection."

Texas Doctors to Speak Before Medical Assistants' Convention

"Progress with a Purpose" will be the theme of the third annual convention of the Texas Medical Assistants' Association, to be held May 20-22 at Houston's Rice Hotel. Functioning with the support and approval of the Texas Medical Association and the American Medical Association, the organization has nine county chapters and 10 members-at-large.

Convention speakers will include Dr. George D. Broyles, Jr., clinical instructor, Baylor University College of Medicine, Houston; David B. Vinson, Ph.D., University of London; Ted Bowen, administrator of Houston's Methodist Hospital; Sam W. Tigner, vice-president of the Houston Medical and Dental Service Bureau; Mrs. May Del Flagg, *Houston Post* club editor.

Also Dr. Thomas L. Royce, clinical associate professor at Baylor University College of Medicine and honorary member of the TMAA; Donald T. Meredith, manager of trade and guest relations, the Upjohn Company, Kalamazoo, Mich.; Mrs. Lillie Woods, San Francisco, national vice-president of the group; Dr. Robert J. Wise, clinical assistant professor, Baylor University College of Medicine.

Blue Cross-Blue Shield of Texas will sponsor a continental coffee honoring newly elected officers of the association.

Advisers of the group are Dr. Albert A. Tisdale, Austin; Dr. Everett C. Fox, Dallas; Dr. Royce, Houston; Dr. Cecil French, San Angelo; and Dr. Milford O. Rouse, Dallas, who is an honorary member of the Texas organization as well as a member of the national advisory board.

President-elect of the medical assistants is Mrs. Judy Coleman, Dallas County, who will be installed in May to succeed Miss Jo Estrada of Bexar County.

Membership in the Texas Medical Assistants' Association is open to any person who has been employed for as much as 1 year as a medical assistant by members of the Texas Medical Association.

The American Association of Medical Assistants was organized in Milwaukee in 1956, the Texas group in the spring of 1957. The American Medical Association has approved the activities of the national group, whose objectives parallel those of the medical profession, and the Committee on Patient Care of the Texas Medical Association has endorsed the objectives of the state and local groups in this state.

Texas Hospital Association To Meet in Dallas May 9-12

The Texas Hospital Association will hear Dr. F. J. L. Blasingame, executive vice-president of the American Medical Association, discuss "Pressing Problems Facing Medicine and Hospitals" when it holds its thirty-first annual convention May 9-12 in Dallas.

Other slated speakers include Congressman Bruce Alger, Washington, D. C.; nationally-known newsman Paul Harvey, Chicago; John Morris, vice-president of purchasing, Lone Star Steel Company, Dallas; Richard L. Johnson, assistant director and secretary, Council on Administrative Practice, American Hospital Association, Chicago; Pat N. Groner, administrator of Baptist Hospital, Pensacola, Fla.

Also among the speakers are Ray E. Brown, president, American College of Hospital Administrators; Frank S. Groner, president-elect, American Hospital Association, Memphis, Tenn.; Dr. Milford O. Rouse, vice-speaker of the American Medical Association House of Delegates, Dallas; Philip R. Overton, Texas Hospital Association and Texas Medical Association legal counsel, Austin.

Topics to be discussed during the session include such subjects as good personnel practices, legislation, interpretation of hospital costs to the community, board-medical staff-administrator relationships, and the new look in nursing education.

Registration will be Monday, May 9, at the Statler Hilton Hotel. All social functions will be at the hotel, and all meetings and exhibits at the Memorial Auditorium. There is no registration fee.

Blewett Elected President-Elect Of Obstetricians and Gynecologists

Dr. E. K. Blewett of Austin was named president-elect of the Texas Association of Obstetricians and Gynecologists at the organization's annual meeting February 13, in Austin. Dr. Blewett also participated on the program for the meeting. The next meeting of the association will be in Houston, February 11, 1961.

Lubbock Hospital to Hold Annual Lectureship in May

May 7 has been designated as the date for the first program on the annual lectureship to be held by the Internal Medicine Department of Methodist Hospital, Lubbock.

Guest speakers will be Dr. William Dameshek, Boston; Dr. William Crosby, Washington, D. C., and Dr. Joseph M. Hill, Dallas.

Topics during the morning session on autoimmune disorders are "Introduction to Autoimmune Diseases," Dr. Dameshek; "Autoimmune Hemolytic Anemia," Dr. Crosby; "Idiopathic Thrombocytopenic Purpura," Dr. Hill; "Systemic Lupus Erythematosus," Dr. Dameshek.

Afternoon topics during the session on myeloproliferative and lymphoproliferative diseases include "Introduction to Myeloproliferative and Lymphoproliferative Diseases," Dr. Hill; "Polycythemia and Erythroleukemia," Dr. Dameshek; "Acute Leukemia," Dr. Crosby.

Topics under the session on intrinsic abnormalities of the erythrocyte: "The Normal Erythrocyte," Dr. Crosby; "Relation of RBC Morphology and Hemolytic Disease," Dr. Hill; "Abnormalities of Hemoglobin and RBC Stroma," Dr. Dameshek; "Enzymatic Abnormalities of Erythrocytes," Dr. Crosby.

Further information may be obtained by writing Dr. Patrick H. Pappas, 3621 21st Street, Lubbock.

American Proctologic Society Dates 13 Guest Speakers for Houston

The American Proctologic Society will hold its sixty-first annual meeting at the Shamrock Hilton Hotel in Houston April 24-27, with a distinguished list of guest speakers included on the program.

These include Drs. Rodney C. Jung, Guillermo M. Carrera, Alton Ochsner, Sr., and Isidore Cohn, Jr., all of New Orleans; Drs. Edgar Poth and Marcel Patterson, Galveston; Dr. John S. Pratt, Jr., St. Louis; Drs. N. C. Hightower and Henry Laurens, Temple; Drs. Michael DeBakey and Denton Cooley, Houston; James C. Hampton, Ph.D., Houston; and Dr. Eugene Gaston, Framingham, Mass.

National president is Dr. Hyrum R. Reichman, Salt Lake City; and Dr. Norman D. Nigro, Detroit, is secretary. Program chairman is Dr. Merrill O. Hines, New Orleans, with Dr. Herbert T. Hayes, Houston, as local arrangements chairman.

The program is of interest to all physicians, house officers, and medical students. All such guests are invited to register and attend scientific sessions free of charge; attendance at social functions will require payment of the registration fee.

V. A. Hospitals, University of Texas Plan Workshop for April 21-23

A workshop for psychologists and psychiatrists of Texas Veterans Administration hospitals will be held at the University of Texas, Austin, from April 21 to 23.

Presenting results of their research work at the meeting will be John Whiting, Ph.D., Harvard University; Julian Rotter, Ph.D., Ohio State University, and Robert R. Blake, Ph.D., University of Texas.

Program planners for the conference, which is jointly sponsored by the Veterans Administration and the University of Texas Department of Psychology, are Robert Morton, Ph.D., chief psychologist at the Houston Veterans Administration Hospital, and Austin Grigg, Ph.D., director of clinical studies in the University Department of Psychology.

Participating also in the program will be Max Houtchens, Washington, D. C., V.A. chief clinical psychologist; I. J. Knopf, Ph.D., Dallas, University of Texas Southwestern Medical School clinical psychology chief; Laurence S. McGaughran, University of Houston; Trenton Wann, Ph.D., Rice Institute; Sidney E. Cleveland, V.A. Hospital, Houston; Joseph Rickard, Ph.D., Temple; A. J. Jernigan, Ph.D., Dallas; J. R. Kinser, San Antonio; Ruth Hubbard, Ph.D., Waco; Wayne Holtzman, Ph.D., Ira Iscoe, Ph.D., and Philip Worchel, Ph.D., all of the University of Texas.

1,275 Future Nurses Attend Austin Meet

Some 1,275 persons from across the state were in attendance when the Texas Association of Future Nurses held its sixth annual convention in Austin March 12.

Officers elected for 1960-1961 included Miss Carolyn Stewart, Dallas, president; Miss Patricia Kilgore, Corpus Christi, vice-president; Miss Jo Jackson, Midland, secretary; Miss Beverly Bryant, Dallas, treasurer; Miss Marilyn Ellison, Fort Worth, chaplain; and Miss Charlene Geisinger, Pasadena, parliamentarian.

Corpus Christi was selected as the 1961 convention site.

The association, a statewide organization for high school girls interested in becoming nurses, is sponsored by the Woman's Auxiliary to the Texas Medical Association, the Texas Graduate Nurses Association, and the Texas League for Nursing. These groups were represented at the meeting by their presidents, Mrs. Haskell D. Hatfield, El Paso; Mrs. Sadie F. Brown, San Antonio, and Miss Stella McCullough, Austin, respectively.

Convention chairman for the Woman's Auxiliary to the Travis County Medical Society was Mrs. Milner S. Thorne, whose co-chairmen were Mesdames F. Murphy Nelson and W. W. Kelton, Jr., all of Austin.

Cleveland to Be Site Of Institute on Alcohol

A 2-day institute on "Alcohol Intoxication and Influence" has been scheduled for May 12 and 13 by the Western Reserve University Law-Medicine Center in Cleveland, Ohio.

Civil and criminal aspects of the topic will be emphasized, and physiological effects of alcohol on the human body, the history and theory of chemical tests, and the scientific equipment available to perform chemical tests will be covered.

Under discussion also will be the preparation of civil and criminal cases involving the issues of intoxication and influence. Planned, too, is a segment of a criminal trial involving the intoxication issue in a traffic manslaughter charge.

Presenting lectures and demonstrations will be members of the Western Reserve University faculty, the professional staff of the Cuyahoga County Coroner's Office, and public officials.

Further information may be obtained by writing Oliver Schroeder, Jr., Director, Law-Medicine Center, 2145 Adelbert Road, Cleveland 6, Ohio.

Houston, Mexico City Sessions Set for Proctologic Societies

The American Proctologic Society will hold its fifty-ninth annual meeting at the Shamrock Hilton Hotel in Houston April 25-27. Immediately following, the group will join the Mexican Proctologic Society for a combined session (April 29-May 1) at the Continental Hilton Hotel in Mexico City.

Program committee chairman for the Houston session is Dr. Merrill O. Hines, 3503 Prytania Street, New Orleans, from whom further information may be requested. Advance registration is not necessary, and the meeting is open to all members of the profession.

National officers of the American society include Dr. Robert J. Rowe, Dallas, treasurer. Houston arrangements chairmen are Drs. Herbert T. Hayes, Harry B. Burr, and J. Wade Harris. APS representative for the Mexico City program is Dr. Charles A. Neumeister, while Dr. Fidel Ruiz-Moreno is secretary of the latter group.

A special program for wives is planned in both cities.

Arthur Flemming Dated For Dallas Food and Drug Meeting

Secretary of Health, Education, and Welfare Arthur S. Flemming will head the list of speakers at the sixty-fourth annual national conference of the Association of Food and Drug Officials of the United States, to be held June 5-9 at the Baker Hotel, Dallas. About 200 members are expected.

The conference will include expert discussions on the narcotics problem, current developments in food additives and color amendments, means of making safer the use of hazardous substances in homes and industry, and problems pertaining to the frozen food code.

Among national officers of the group is J. F. Lakey, secretary-treasurer, who is director of the Division of Food and Drugs, Texas State Department of Health.

OF GENERAL INTEREST

Personals

Dr. Milford O. Rouse, Dallas, discussed the dangers of government intervention in the health affairs of the nation's aged at a 2-day conference in February of the American Medical Association Committee on Aging. Held in New Orleans by the committee and the medical societies of Arkansas, Louisiana, Mississippi, and Texas, the meeting was called to explore the opportunities for positive health and meaningful living among older persons.

Dr. Jay J. Johns, Taylor, has been named chairman of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association.

Dr. W. P. Higgins, Jr., Fort Worth, has received the highest honor a Catholic bishop can confer—the Holy Trinity Award. Dr. Higgins was cited for 15 years of outstanding service in Catholic charities and medicine at the annual meeting of Catholic Charities, Diocese of Dallas-Fort Worth, in February.

A native Texan and brother of two Texans, *Dr. Tom Douglas Spies,* president-elect of the Southern Medical Association, died February 28, 1960, in New York.

Director of the Hillman Nutrition Clinic in Birmingham, Ala., at the time of his death, Dr. Spies was connected with nutrition clinics in Havana, Cuba, and Chicago, and he was professor of nutrition and metabolism and department head at Northwestern University.

In 1957, Dr. Spies was given the Distinguished Service Award by the American Medical Association for his contributions in the field of deficiency diseases and clinical nutrition.

A graduate of Bonham High School and the University of Texas, Dr. Spies received his medical degree from the Harvard Medical School in 1927. Survivors include two brothers, *Dr. John H. Spies* of Austin and Allen Spies of Leonard.

Dr. N. E. Dudney, League City, has been presented that town's "Outstanding Citizen" award at the annual Chamber of Commerce banquet. During presentation ceremonies, Dr. Dudney was commended for "his capable leadership and stimulating interest."

Dr. Howard C. Hopps, professor and chairman of the Department of Pathology at the University of Texas Medical Branch, Galveston, has been named "Boss of the Year" in that city. The award was made at the sixth annual "bosses'" dinner of the Galveston County Chapter, National Secretaries Association, Inc.

Dr. Thomas R. McElhenney, Austin, presented a paper, "Nasal Allergy in Infants and Children," at the sixteenth Congress of the American College of Allergists in Miami.

Dr. Eugene Schoch, Austin, is among contributors to *1960 Current Therapy.*

Dr. Maurice Jacobs, Austin, was recently named vice-president of the Jewish Community Council of Austin, while *Dr. Otto Lippmann* became a member of its board of directors.

Dr. and Mrs. Walter S. Patton, Amarillo, are the parents of a daughter, Kelly, born February 7.

Dr. W. R. Gaddis and *Dr. R. B. Homan, Jr.,* were moderators for a recent symposium on clinical medicine and surgery held in El Paso under auspices of the El Paso County Medical Society and the Lederle Laboratories. The all-day session was open to physicians from West Texas and New Mexico.

Dr. R. W. Kimbro, Cleburne, is new councilor-elect from Texas for the Southern Medical Association, an appointment made as one of his last official acts by the late *Dr. Tom Spies,* who was president-elect.

Death claimed El Paso mining engineer *Oscar C. Rheinheimer,* brother of *Dr. E. W. Rheinheimer* of that city, on March 8.

Dr. Joseph V. Hopkins, Victoria physician who has carried on his practice in spite of a laryngectomy for cancer 30 years ago, was honored by Catholic doctors in Boston March 27. St. Luke's Guild, an association of Catholic physicians, presented him the Laetare Medal at its annual dinner.

On March 8, 1960, death claimed *Mrs. Luta Bob Archer,* mother of *Dr. John Archer,* Amarillo, and *Dr. Richard K. Archer,* Dallas.

Yale School of Medicine to Observe 150 Years in October

A century and a half of existence will be marked by the Yale School of Medicine on October 28 and 29 of this year. Sir Howard Florey of Oxford, England, will be among speakers featured during the special observance of the nation's fifth medical school to be established. Charter for the establishment of the Medical Institution of Yale College was granted in October, 1810, by the Connecticut General Assembly.

Medical Students Participate In Army Survival Demonstrations

Operation Knothole, 48 hours of lectures and field exercises on after-effects of atomic explosions, was viewed recently by 200 future doctors and nurses from the University of Texas Medical Branch at Galveston.

Following orientation at Brooke Army Medical Center at Fort Sam Houston, 3,000 soldiers demonstrated the disaster at Camp Bullis near San Antonio.

Demonstrations included how to reduce confusion and expedite patient recovery by alternating patient movement with patient care in step by step methods from the disaster scene to permanent hospitals.

Patients were divided into categories according to the seriousness of their injuries with those suffering lesser wounds being treated first. Thus, they could be free to assist litter bearers and medical aid personnel in care of others. Conversely, those who were expected to die were placed in an "Expectant Area," and temporarily abandoned so that limited medical resources might be applied where chances of saving life were possible.

Other points shown during the operation were military organization of attack and defense tactics, gathering of wounded over widely scattered terrain, sorting patients to determine the next stage of treatment and movement, use of jeeps, trucks, helicopters, and field surgery with nominal equipment. Also simulated for onlookers was an atomic hit by a tactical weapon yielding 20 kilotons.

To demonstrate what happens to human tissue encased in skin when hit by a high powered rifle bullet, a plastic sack was filled with sauerkraut. When hit, its contents were scattered over a 20 foot circumference.

Major General William E. Shambora, medical commander at the base, and Dr. Truman G. Blocker, Jr., who led the group from the Medical Branch, announced that the event will be re-staged for medical schools throughout the country.

Southwestern Medical Foundation

Dr. George W. Dana of New York has been named executive director of Southwestern Medical Foundation in Dallas, Karl Hoblitzelle, president, has announced. A native of Ohio, Dr. Dana received his bachelor of arts degree from Dartmouth and his medical degree from Cornell. He was a medical officer with Patton's Third Army in World War II. He has held numerous medical positions and assignments, among the most recent of these being his membership in a 10-doctor United States delegation to the World Health Assembly under chairmanship of the Surgeon General.

A $22,500 cancer research grant has been presented to the University of Texas Southwestern Medical School by the Dallas Chapter, Fraternal Order of Eagles.

Southwestern Medical Foundation has made a grant of $7,700 to the University of Texas Southwestern Medical School to be used in support of a heart research project being directed by Dr. Richard Ernst, assistant professor of thoracic surgery. Official title of the project is "Pathogenesis of Shock, Peripheral Cyanosis and Pooling of Blood Secondary to an Abnormally Low Blood pCO_2."

The Grady Reddick Memorial Lectureship has been set up to perpetuate the memory of the late Dr. Walter Grady Reddick, clinical professor of medicine at the University of Texas Southwestern Medical School, who was one of the first physicians to link migraine headaches with personality traits. Funds contributed to the Grady Memorial Lectureship are being received by Southwestern Medical Foundation. Dr. Morris Horn, president of the Dallas Academy of Internal Medicine, whose executive committee is heading the fund campaign, says his group hopes to obtain between $12,000 and $15,000 in endowment funds.

Ground was broken last December for the construction of the new 532-bed, $10,000,000 St. Paul Hospital, a Southwestern Medical Center development, slated to be in use in 1962.

Texas Doctors, Legislators Discuss Need for Attack on Regional TB Nests

A more intensive case-finding program to stamp out the spread of tuberculosis in certain areas of Texas was urged by Dr. Elliott Mendenhall of Dallas, chairman of the Texas Medical Association Committee on Tuberculosis, when he appeared before the state Legislative Budget Board in Austin February 10.

Legislative and medical officials appearing, in addition to Dr. Mendenhall, included Dr. C. J. Ruilmann, director of Texas State Hospitals and Special Schools; Dr. Nat Goldsmith, a member of that board; and Senator Abraham Kazen of Laredo, who outlined the tuberculosis incidence in Webb County. Lt. Governor Ben Ramsey is chairman of the Legislative Budget Board. Other legislators attending were Senators Wardlow Lane of Center, Dorsey Hardeman of San Angelo, and Crawford Martin of Hillsboro; Representatives Truett Latimer of Abilene, Bo Ramsey of Beckville, and John Huebner of Bay City.

Dr. Mendenhall stated that tuberculosis bacilli are building up resistance to preventive drugs which are often used to cure minor injuries. He urged extensive skin testing and chest x-ray surveys south of a line from El Paso to Houston, with special emphasis in searching out tuberculosis "nests, both geographical and personal." He also urged detected cases be reported to the State Health Department or county medical societies.

Dr. Ruilmann said that tuberculosis has been somewhat on the decline in Texas generally, but that certain areas still have a high incidence rate.

Problems in Home Care Of Tuberculous Patient

Development of present day drug therapy used in treatment of tuberculosis has tended to popularize home treatment of the disease. In a few instances, such treatment is not only practical but also wise. However, it is surrounded by many problems. Some of these are obvious and others are real, but unrecognized.

As a rule, the problems are governed by three factors:

1. Type of patient is one factor. Is the patient cooperative? Is he concerned about the welfare of those in contact with him at home? Will he cooperate and follow instructions when the doctor or others in charge of his case are out of sight? Is his sputum positive or negative? Does he understand the principles of sanitation? Will he take his medication?

2. The second factor is governed by facilities in the home where the patient is being treated. Can the patient have his own private "infirmary" within the home? Does he share a bath with others? Can sputum be disposed of adequately? Will nutrition be adequate? Is the home accessible to medical consultation in case of emergencies?

3. The third factor is concerned with other occupants in

the home. Are children present? Can other members of the household be taught the proper respect for the disease? Will his presence create a real health hazard?

All of the preceding questions should be considered carefully before treatment is begun at home.

Obviously, there is a place for the home in the treatment of tuberculosis, but ideally it should follow an initial period of hospitalization. During this time the patient's sputum should be converted to negative, he should be educated about the nature of the disease and he should be instructed in what is required of him after he leaves the sanatorium. Meanwhile, the entire household can be prepared to receive him, thus forming an important link in the rehabilitation of the patient. (Preparing the household for the patient is just as important as getting the patient ready to come home.) An atmosphere conducive to continued improvement must be maintained, and the importance of continuing competent medical supervision cannot be overemphasized.

—Committee on Tuberculosis,
Texas Medical Association.

Medical Research Foundation of Texas

Dr. Val C. Baird, chief physician of Humble Oil and Refining Company, Houston, has been elected president of the Medical Research Foundation of Texas, its board chairman, former Governor Dan Moody, has announced.

Dr. Baird is chairman of the Texas Medical Association's Committee on Industrial Health and is active in affairs of the Medical Advisory Committee of the American Petroleum Institute. He succeeds Dr. G. V. Brindley, Sr., Temple, as president of the Medical Research Foundation.

Other new officers are French Robertson, Abilene independent oil operator and former chairman of the Board for Texas State Hospitals and Special Schools, first vice-president; Dr. H. W. Paley of the University of Texas Medical Branch, Galveston, secretary; Marvin K. Collie, president of Houston's National Bank of Commerce, treasurer. Executive vice-president is Sloane Wingert, Houston.

The foundation is a nonprofit corporation dedicated to the encouragement and support of basic medical research in Texas, and it has established advisory groups throughout the state, working in accord with practicing physicians and dentists interested in advancing basic research projects.

The foundation itself does not conduct actual research projects nor does it maintain any research facilities. It processes and acts upon requests for research funds in Texas and endeavors to secure financial support for worthwhile programs. Grants totalling $52,000 have been channeled through the foundation to five medical and dental schools in Texas during the past 20 months. In some communities the foundation is supported by United Fund or Community Chest appeals, but for the most part fund-raising efforts are directed to individuals and corporations.

Niese Succeeds Ogle in Air Force Post

Major General O. K. Niese, USAF, MC, is now United States Air Force Medical Service surgeon general, replacing Major General Dan C. Ogle, who retired recently.

The word "apothecary" derives from a Greek noun meaning "storehouse." Some trace the druggist title, pharmacist to the Greek word for "remedy." But other scholars derive it from an ancient Egyptian term meaning "the practise of witchcraft," according to Ketchum & Co. Inc.

"Next—Let's Conquer Mental Illness!"

"Next—Let's Conquer Mental Illness" is a key phrase in stories and advertisements used during the 1960 national mental health campaign, now in progress April 15-May 31.

Sponsored by the National Association of Mental Health, the campaign is being conducted in every community of the United States, particularly in those areas where the drive is conducted by the 800 affiliates of this more-than-a-million citizens' group.

This year about 300,000 Americans will become mental patients for the first time, a fact sheet released by the association reveals. At least 17,000,000 Americans (one in every 10) are now suffering from a mental or emotional disorder, and half the cases a physician sees are tied up with such disorders.

At the same time, reports the association, the average state hospital has less than half the doctors it needs, one-third the social workers it needs, two-thirds the psychologists it needs, and one-fifth the nurses it needs. Community mental health clinics now number a little over 1,300, half of them part-time, while at least 3,300 full-time clinics are needed to have one clinic per 50,000 population.

Major Building Plans Announced For Corpus Children's Hospital

Plans were announced in February to build major additions to the Driscoll Foundation Children's Hospital in Corpus Christi. First step will be to erect quarters for 50 private patient beds, scheduled for completion by May, 1961.

Nucleus of the expansion plans will be a pediatric center, a "mother hospital," which will provide medical and surgical care for a number of separate building units on the hospital's acreage. Each smaller unit will have separate administrative boards and financing, although they will share certain auxiliary facilities. Master planning and administration will be conducted by the South Texas Children's Medical Center Foundation, newly formed organization. Grounds were provided by the Driscoll Foundation.

With an ultimate completion goal of 10 years, the center will include eventually a rehabilitation center with 50 beds for in-patients and extensive out-patient treatment facilities. Treatment here will be concentrated on children with handicaps from such diseases as polio, muscular dystrophy, arthritis, and cerebral palsy. Also to be included will be two additional floors of the present charity hospital for paying patients, a building for completely handicapped children, a convalescent home with a 25 bed nursery, cottages for 25 more, a small animal laboratory, a Parent-Child Guidance Center, a greenhouse, and a building for the Nueces County Medical Society.

A Portrait of Sigmund Freud

An etching of Sigmund Freud in his middle years, done by Viennese artist Max Pollak, hangs in the Meeting Room of the Jesse H. Jones Library Building, Texas Medical Center, Houston. The etching is the recent gift of Mr. and Mrs. Julius Fohs of Houston, who decided to donate it to the Houston Academy of Medicine so that it might be appreciated by a wider audience. Mr. Fohs, a geologist, began collecting Pollak's work after meeting him in 1918.

Pollak became acquainted with Freud in 1913 when the publisher of Freud's early works commissioned him to make the portrait. Artist and subject found grounds for a pleasant relationship in their common interest in Egyptian and Greek archeology. Pollak, in fact, included in the etching some archeological relics which Freud kept on the desk of his study. In his biography of Freud, Ernest Jones

Sigmund Freud

describes the desk at which Freud wrote as being "crowded with his favorite statuettes and similar objects which present a rather puzzling appearance in the well-known etching by Max Pollak depicting him seated there."[1] Jones goes on to describe other relics and items in Freud's study, such as Egyptian stone reliefs, a bronze head of Buddha, a Chinese bowl purchased in America on his visit here in 1909, an etching of the great temple of Abu Simbel, and a plastic copy of the marble relief of the famous Gradiva.

Pollak made a serious effort to know as much as possible about his subject before beginning the drawing. For a semester he attended Freud's lectures at the University of Vienna and read his published works. Freud liked the finished portrait and refused to pose for any other artist for many years.[2] Prior to the time when Max Pollak did his drawing Max Eitingon, Freud's lifetime friend and fellow analyst, "wanted him to allow Professor Orlik, a distinguished artist, to make an etching of him, one to be better than Struck's, . . . Freud refused, saying that the one Schmutzer had made a few years before could not be surpassed and anyhow he had promised Max Pollak the 'final visage.'"[3]

Before World War II, Pollak left Vienna to come to the United States. He left behind him many of his possessions, including the copper plates of the etching, all of which were destroyed by the Nazis during the war. As a result, only a few known copies of the portrait of Freud now remain.

In this country Pollak's work has taken on a new character. He has made etchings of Mexican scenes. For the Fohs he has done two etchings, one of a Texas oil well scene, the other of an area of New York City. Pollak is now living in Sausalito, Calif., and exhibiting his work in San Francisco.

Pollak's portrait of Freud apparently meant a great deal to Theodor Reik, psychoanalyst and author, for in the preface of his "From Thirty Years With Freud"[4] he recalls how he was moved after looking at the etching for some time. Reik's comments on the portrait describe it well. The drawing is set in "A dimly lighted room. In the foreground, on the desk, antique bronzes and figurines, dug up out of the ruins of centuries, phantoms of the past . . . the sculptures seem symbolic. For the life that Freud showed us was resurrected like them from the dust of centuries . . . Freud's head, bent forward slightly, outlined distinctly. The eyebrows lifted as though in deep attention. Ridges on the high forehead and two deep furrows running down from the mouth to the short white beard. The eyes gaze into the beholder and yet see beyond him . . . . They have an expression of hardy quest, as though their gaze had wholly merged into their object; and yet they valued that object only for the knowledge it gave."

This portrait is valued for both artistic and historical reasons and is a gift greatly appreciated by the Houston Academy of Medicine.

—JAMES A. KNIGHT, M.D., Houston.

Suggested Reading

A selected list of items on Freud, psychiatry, psychology, and psychosomatic medicine available on loan from the Memorial Library of the Texas Medical Association, Austin, follows:

Alexander, Franz: Sigmund Freud, AMA Arch. Neurol. & Psych. 43:575-580 (March) 1940.

Barrett, William G.: A Hitherto Unremarked Error of Freud's, Psycho-analyt. Quart. 28:247-248, 1959.

Fortes, Meyer: Malinowski and Freud, Psychoanalysis and the Psychoanalytic Rev. 45:137-145 (Spring-Summer) 1958.

Glover, Edward: The Uses of Freudian Theory in Psychiatry, Brit. J. M. Psychol. 31:143-152 Parts 3 & 4 1958.

Overholser, Winfred: The Meaning of Freud for Our Time, Internat. Rec. Med. 164:249-257 (May) 1951.

[1] *The Life and Work of Sigmund Freud, vol. 3, New York, Basic Books, 1957, p. 317.*

[2] *Pollak described his relationship to Freud and gave details of making the etching in a letter to the author.*

[3] *Jones, op.cit., p. 153.*

[4] *Trans. by Richard Winston, New York, International Universities Press, 1949, pp. viii-ix.*

Zilboorg, Gregory: Freud's Fundamental Psychiatric Orientation, Internat. J. Psycho-Analysis 35:1-5 Part II 1954.

Zilboorg, Gregory: Freud's One Hundredth Anniversary, The Psychoanalyt. Quart. 25:139-146 1956.

Zilboorg, Gregory: Sigmund Freud in the Perspective of Medical History, Bull. New York Acad. Med. 32:894-902 (Dec.) 1956.

The Psychiat. Quart., (Freud Centenary Issue), vol. 30, no. 4, 1956.

The following journals in the field of psychiatry may be found in the Library:

Acta Psychiatrica et Neurologica.
American Journal of Psychiatry.
American Journal of Psychology.
American Journal of Psychotherapy.
Archives of General Psychiatry.
Archives of Neurology & Psychiatry.
British Journal of Medical Psychology.
Bulletin of the Los Angeles Neurological Society.
Diseases of the Nervous System.
Journal of Applied Psychology.
Journal of Clinical Psychology.
Journal of Nervous & Mental Diseases.
Journal of Neurology, Neurosurgery, Psychiatry.
Journal of Neuropathology & Experimental Neurology.
Journal of Neurophysiology.
Psychiatry.
Psychoanalytical Quarterly.
Psychosomatic Medicine.

Gifts to the Library

Dr. Fred L. Adair, Florida, 4 reprints and 3 journals.
Dr. Otto Brandt, Jr., Austin, 31 journals.
Dr. Charles M. Darnall, Austin, 4 bound journals and 206 books.
Dr. Guy T. Denton, Jr., Dallas, 104 journals and 20 books.
Dr. Enid Gilbert, Austin, 132 journals.
Dr. Homer Goehrs, Austin, 54 journals.
Dr. Richard B. Johns, Abilene, 24 tapes.
Dr. J. Edward Johnson, Austin, 114 journals, 25 reprints and pamphlets.
Dr. Hyman J. Kaplan, Bay City, 10 books and 1 journal.
John Kirby, Ph.D., Austin, 66 journals.
Dr. Georgia Legett and Dr. Carey Legett, Austin, 40 journals.
Mrs. Harry J. Leon, Austin, 6 journals.
Dr. Robert W. Loveless, Bastrop, 34 journals and 4 books.
Dr. William P. Morgan, Austin, 112 journals.
Philip R. Overton, Austin, 344 journals.
Mrs. William S. Sanders, Jasper, 30 tapes.
Dr. Teddy M. Sousares, Austin, 85 journals.
Dr. Claude A. Selby, Sinton, 243 journals.
Dr. B. O. White, Austin, 18 journals.
Dr. David R. Womack, Austin, 20 journals.

★ Books

Books Newly Acquired

American College of Surgeons, Surgical Forum: vol. 10, 1959, Chicago, American College of Surgeons, 1960.

American Medical Association: *New and Nonofficial Drugs,* 1960, Philadelphia, J. B. Lippincott, 1960.

Cajal, Santiago Ramon y: *Studies on Vertebrate Neurogenesis,* Springfield, Ill., Charles C Thomas, 1960.

Coates, John Boyd, Ed.: *Neurosurgery, Surgery in World War II,* Washington, Office of the Surgeon General, Department of the Army, 1959.

Conn, Howard Franklin: *Current Therapy, 1960,* Philadelphia, W. B. Saunders, 1960.

Cosentino, Rodolfo: *Atlas of Anatomy and Surgical Approaches in Orthopedic Surgery—Upper Extremity,* Springfield, Ill., Charles C Thomas, 1960.

Davis, Loyal, Ed.: *Christopher's Textbook of Surgery,* ed. 7, Philadelphia, W. B. Saunders, 1960.

DeJong, Russell N.: *Neurologic Examination,* New York, Hoeber-Harper, 1958.

Gilman, Leonard: *Insomnia and Its Relation to Dreams,* Philadelphia, J. B. Lippincott, 1958.

Goss, Charles Mayo: *Brief Account of Henry Gray and His Anatomy, Descriptive and Surgical,* Philadelphia, Lea and Febiger, 1959.

Haik, George M.: *Symposium on Diseases and Surgery of the Lens,* St. Louis, C. V. Mosby, 1957.

Harrison, Tinsley Randolph: *Principles of Internal Medicine,* ed. 3, New York, McGraw-Hill, 1958.

Inter-Society Cytoloty Council, Transactions of the 6th Annual Meeting: New York, Nov. 13-15, 1958.

Jelsma, Franklin: *Primary Tumors of the Calvaria,* Springfield, Ill., Charles C Thomas, 1960.

Licht, Sidney: *Massage, Manipulation and Traction,* New Haven, Conn., Elizabeth Licht, Publisher, 1960.

Medical Fee Guide, Stanford, Calif., Medical Reference Bureau, 1959.

Rule, Colter: *A Traveler's Guide to Good Health,* New York, Doubleday, 1960.

Scheer, Bradley T.: *General Physiology,* New York, John Wiley, 1953.

Schwartz, Laszlo: *Disorders of the Temporomandibular Joint,* Philadelphia, W. B. Saunders, 1959.

Sterling, Julian A.: *Biliary Tract,* Baltimore, Williams and Wilkins, 1955.

Titchener, James L., and Levine, Maurice: *Surgery as a Human Experience,* New York, Oxford University Press, 1960.

Year Book of the Ear, Nose and Throat, 1959-60, Chicago, Year Book Publishers, 1960.

Book Notes

A Short History of Anatomy and Physiology From the Greeks to Harvey

CHARLES SINGER. 209 pages. $1.75. New York, Dover Publications, Inc., 1958.

This inexpensive paper bound book is presented interestingly and covers the period from 50 B.C. in Grecian times to William Harvey. Harvey's epoch making paper, prepared meticulously, was delivered in a conservative and almost obscure manner by publication in Frankfort, Germany, in 1628.

The conciseness of his observations and the simplicity of his procedures with experimental proof were typical of his analytical mind. It was this type of mind that would not let him deviate into the philosophies which had been handed down from the time of Galen. It led to such fundamental observations as the following: during cardiac contraction while the size and breadth of the heart are decreasing, the heart actually elongates so that the apex strikes the anterior chest wall during this period. He found that the explanation for arteries being empty in death lay in the fact that the animal ceased to breathe, and the heart

continued to beat after blood was no longer delivered to it from the pulmonary vessels. Likewise, it was he who found the difference between veinous and arterial pressures by experimentation on living subjects.

Many other contributions are not covered here, but no apology is necessary. No one in the time or space allotted could cover the multitudinous and epochal observations which laid the groundwork for someone like Harvey with his genius for accurate observation to unravel. This review is designed to whet the reader's interest in medical history, past and present. All of us will make better physicians and better citizens if we but take the time to weigh and consider the contributions of our predecessors under circumstances and conditions much less favorable than our own.

—Joe C. Rude, M.D., Austin.

Pediatric Neurology

STANLEY S. LAMM, M.D., Clinical Professor of Pediatrics, State University of New York, College of Medicine at New York City; Neurological Consultant, Pediatric Department, Kings Country Hospital (State University Division), Brooklyn, N. Y. 495 pages. $12.90. New York, Lansberger Medical Books, Inc., 1959.

Covering a much needed area for the psychiatrist, pediatrician, and general practitioner, Dr. Lamm shows his orientation as a pediatrician and a neurologist throughout the book.

The book is not intended to be exhaustive nor simply a compendium of information. It is primarily aimed at giving explanation of the various problems of the nervous system seen in children, with outlines of diagnosis and treatment. Sections such as those on phenylpyruvic oligophrenia or galactosemia are lucid, succinct, and apparently up to date. The section on brain tumors is brief but helpful. It gives the impression of being written by someone with much firsthand experience with these problems.

Photographs included are of good quality and are helpful.

Heller's disease is not mentioned. The author may not feel that the entity is frequent enough or sufficiently established as an entity.

Dr. Lamm is to be commended for a creative effort which has resulted in a useful text.

—John A. Boston, Jr., M.D., Austin.

Plastic Arterial Grafts

W. STERLING EDWARDS, M.D., Assistant Professor of Surgery, Medical College of Alabama, Birmingham. 105 pages. $4.50. Springfield, Ill. Charles C Thomas, 1957.

Concerned chiefly with reporting progress in the field of arterial grafts, Dr. Edwards relies heavily on literature as against clinical experience; nevertheless, he contributes an excellent presentation of clinical application of grafting procedures. It might be considered weak, were it not that this field is in such a flux of rapidly developing change.

The bibliography accompanying each chapter is excellent reference for further study. It is well indexed, and for those in small communities where the resources of the large hospital are absent, it has much to offer.

The Management of Menstrual Disorders

C. FREDERIC FLUHMANN, M.D., C.M., Clinical Professor of Obstetrics and Gynecology, Stanford University School of Medicine, San Francisco; Assistant Visiting Obstetrician and Gynecologist, Stanford-Lane Hospitals. 338 pages. $8.50. Philadelphia and London, W. B. Saunders Company, 1956.

This is the second book of Dr. Fluhmann's dealing with menstrual disorders. New factors of primary consequence and a refinement of diagnostic and therapeutic procedures have made it seem desirable to present a new discussion of the subject. Emphasis is strongly on clinical management and is primarily for the medical practitioner.

The various menstrual disorders are well discussed in their separate entities, although the broad view of their place in general medicine is constant. Much attention is given to the two age epochs, adolescence and climacterium. From background of extensive investigations of 30 years, excellent reference sources at the end of each chapter, and good cross indexing, the book presents a highly readable and instructive format for the general practitioner.

Cold Injury, Ground Type

COL. TOM F. WHAYNE, MC, USA (Ret.), Professor of Preventive Medicine, School of Medicine, University of Pennsylvania, Philadelphia, and MICHAEL E. DEBAKEY, M.D., Professor of Surgery and Chairman of the Department, Baylor University College of Medicine, Houston, and formerly Col., MC, AUS. 570 pages. $6.25. Washington, D. C., Office of the Surgeon General, Department of the Army, 1958.

A very comprehensive book on the ground type of cold injury which occurred during World War II, this book is filled with excellent photographs showing the results of cold injury among military personnel during World War II. The basic causes of cold injury were given as cold, wet, or cold and wet in combination.

This book has three main purposes: to summarize what has been learned of the nature of this injury, including its military cost, rehabilitation of the patients, its management, physiology, and epidemiology; to record the history and findings of cold injury, ground type; and to formulate a plan for its prevention and control in the future.

Experimentation in Man

HENRY K. BEECHER, M.D., Anesthesia Laboratory of Harvard Medical School, Massachusetts General Hospital. 80 pages. $3.50. Springfield, Ill., Charles C Thomas, 1959.

★ Texas Medical Association

Texas Doctors, Congressmen Hold Washington Forand Conference

Texas physicians representing each congressional district, Texas Medical Association's general counsel, Philip R. Overton, and the Association's Executive Secretary, C. Lincoln Williston, made a Washington "pilgrimage" early in March to discuss Forand-type legislation with Texas Senators and Congressmen.

The result: on the whole, cordial and sympathetic reception by the statesmen, with strong assurances from the great majority that they oppose any "socialization of medicine." At the same time, the Congressmen emphasized that the medical profession must present its own positive and carefully planned program in the near future.

The entire medical delegation was received by Senate Majority Leader Lyndon B. Johnson and spent an hour with him. Senator Ralph Yarborough, also, talked with the entire group for an hour. Participating physicians were guests of the Congressmen at their regular weekly luncheon in the private dining room of the Speaker of the House of Representatives.

In the evening, Texas Senators and Congressmen and their wives were complimented with a reception and dinner at the Statler Hilton Hotel by the Texas physicians. The Lone Star doctors also spent some time in Washington

conferring with the American Medical Association's staff there.

Taking part in the project were Dr. F. W. Yeager, Corpus Christi; Dr. N. L. Barker, Paris; Dr. R. H. Bell, Palestine; Dr. J. W. Birdwell, Tyler; Dr. Stanley W. Bohmfalk, Weslaco; Dr. G. W. Cleveland, Austin; Dr. Robert L. Daily, Wichita Falls; Dr. Joe R. Donaldson, Pampa; Dr. Carlos E. Fuste, Jr., Alvin; Dr. William H. Gordon, Lubbock; Dr. R. W. Kimbro, Cleburne; Dr. A. R. Kirkley, Belton; Dr. S. Braswell Locker, Brownwood; Dr. E. L. Mueller, Sr., San Antonio; Dr. James W. Rainer, Odessa; Dr. Milford O. Rouse, Dallas.

Also, Dr. Mal Rumph, Fort Worth; Dr. W. M. Sherrill, Houston; Dr. Robert F. Short, Dallas; Dr. Vance Terrell, Stephenville; Dr. J. M. Travis, Jr., Beaumont; and Dr. J. M. Coleman, Austin.

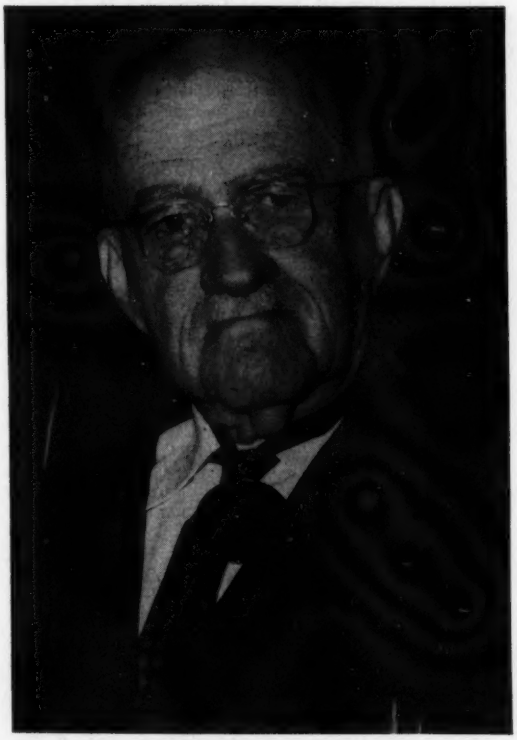
PROFILE IN LEADERSHIP

Youngest TMA President, W. B. Russ Fought for Medicine with Words, Law

In the spring of 1909 in Galveston, members of the Texas Medical Association elected their forty-first president unanimously and by acclamation.

He was a bespectacled, mustachioed young man of 35 named Witten Booth Russ—so far as is known, still the youngest person ever to have been elected to this office and, at that time, already a veteran of several important medical battles.

Dr. Russ was born in Kingston, La., in 1874, received his medical degree from the University of Pennsylvania, and joined the Texas Medical Association immediately after beginning his practice in San Antonio in 1901. From then until the time of his election, he never missed a meeting of the state organization.



Dr. W. B. Russ

He was one of the Association's reorganization leaders in 1903, served as first chairman of the Board of Councilors (1905-1909), and was chairman of the Committee on Public Policy and Legislation before becoming president.

Dr. Russ has been described by some of his friends as one of "the fightingest, writingest" presidents the Texas Medical Association has had, and these are both deserved compliments.

During the stormy days of 1906-1907, he was instrumental in securing passage by the Texas Legislature of five major medical bills (Medical Practice Act, the Anatomical Law, the Board of Health Law, the Tuberculosis Sanatorium Law, the Leprosarium Bill, and the Pure Food and Drug Act). He expended great effort to raise the educational standards of medical schools, and his continuous emphasis on the value of the *Texas State Journal of Medicine* resulted in early prestige for the *Journal* among Association membership. Between 1900 and 1910, he saw, and helped accomplish, the growth of the state association from 300 to about 3,000 members.

Just as he fought medical quacks and nostrum frauds in the early days of Texas medicine, Dr. Russ directed his wrath and a colorful barrage of words, in later decades, toward such diverse subjects as FDR and the New Deal, "pagan funeral orgies," medical scare campaigns, "the farewell state," public relations men, Communists, overspecialization in the medical profession, reformers and do-gooders, and Harry Truman.

He spoke entertainingly of these things before medical and civic groups, and he wrote of them with vigor, humor, and biting satire in essays, verses, voluminous personal correspondence, and a book, "A Doctor Looks at Life," published in 1952 by the Naylor Company. The book was compiled after a newspaper editor told him he should get his writing published "and then flee the country!"

Russ-isms, like the tall tales of Boyce House, have been quoted from one end of Texas to the other. He has told his physician friends, "On behalf of those of us who have

---

The article on Dr. Russ is the first of a series on past presidents of the Texas Medical Association to appear in the Texas State Journal of Medicine.

already lived too long, let me urge you to make the most of today, for when tomorrow comes you will be shocked to know that seniority in Medicine rates about as does seniority in the red light district and politics—a bad past and no future!"

Of the New Deal he remarked, "These New Deal planners of a better world have made logic or 'horse sense' asinine. The trouble is, they pay little attention to logic and the horse has no sense . . ."

His frequent, rather grisly, comment about funerals has been, "We can, at least, save the family suffering by leaving off all doleful ceremony and have ourselves cremated in private, so snoopers will not hang around to see what's cooking."

"Women Are Here to Stay" is the title of a Russ essay which asserts in part, "Leaders of men are always followers of women, and a wife is the real head of the family, the husband being lucky to serve as Chairman of the Entertainment Committee. There are no women after-dinner speakers because they won't wait until after dinner, and they prefer to let the men make fools of themselves by talking at the wrong time."

Throughout his life, however, Dr. Russ has accomplished even more "doing" than talking or writing. A busy surgeon in San Antonio, he found time for many other medical assignments and has been awarded many honors, of which only a smattering can be mentioned here.

He was a Texas Medical Association trustee for 25 years and a delegate to the American Medical Association for nine, served as president of the Texas Surgical Society, was chairman of the San Antonio Board of Health, and a member of the Texas State Board of Health. During World War I, Dr. Russ represented Texas in mobilization of medical resources as aide to the Governor. In 1931-1932, he and the late Dr. Sam Thompson organized the International Post-Graduate Assembly. In November, 1941, Dr. Russ was appointed senior surgeon with the United States Public Health Service and was assigned duty as regional medical officer of the Eighth Civilian Defense Region.

Now 85, Dr. Russ has been "retiring gradually" from the practice of surgery, a process he describes as being "as painful as cutting off a dog's tail an inch at a time." Those who know him, however, are not at all surprised that his so-called retirement period finds him with an appointment as lecturer in surgery at the University of Texas Medical Branch in Galveston, two books in progress, and a habit of spending summers in San Francisco, justly renowned as one of America's livelier cities.

As Dr. Pat Ireland Nixon, biographer of the Texas Medical Association, once wrote: "The ingredients that have gone into the makeup of this unusual man are many and varied: some are primitive, some are bizarre, some are artistic, some are unique, many are old-fashioned—all are interesting. Of the combined ingredients there could be but one result—Dr. Witten B. Russ."

★ District Societies

Third District Hears Distinguished Quintet of Speakers

Five distinguished out-of-state physicians were dated as speakers for the April 2 annual meeting of the Panhandle District Medical Society (District 3) in Lubbock.

Dr. Curtis P. Artz, associate professor of surgery, University of Mississippi School of Medicine, Jackson, Miss., discussed "Intravenous Nutrition" and "Staphylococcal Infection in Hospitals."

Dr. Conrad G. Collins, professor and chairman, Department of Obstetrics and Gynecology, Tulane University School of Medicine, New Orleans, discussed "The Management of Cancer of the Vulva" and "The Early Repair of Vesicovaginal Fistulas."

Dr. Dalton Jenkins, associate professor of medicine and head of the Section on Endocrinology, University of Colorado School of Medicine, Denver, spoke on "Hypoparathyroidism, A Diagnostic Problem" and "An Evaluation of Adrenal Steroids in Therapy."

Dr. Raymond E. Jordan, professor of otology, University of Pittsburgh School of Medicine, chose as his topics "Diagnosis and Management of Meniere's Disease" and "The Evaluation of Mobilization Surgery."

Dr. Jerome W. Bettman, clinical professor of ophthalmology and otolaryngology, Stanford University School of Medicine, San Francisco, discussed "The Surgery of Complicated Cataracts" and "Complications of Cataract Extractions."

In panel discussions, Drs. Artz, Collins, and Jenkins discussed "Abdominal Trauma Complicated by Thrombo-Embolism" and "Hypothyroidism in Pregnancy," while Drs. Jordan and Bettman spoke on "Carcinoma of the Eyelid" and "Glioma of the Medulla."

In addition to the scientific sessions, the meeting program included technical exhibits, a cocktail party for which Mead Johnson and Company was host, and a dinner-dance.

Dr. May Owen Speaks To Ninth District Physicians

Dr. May Owen, then President-Elect of the Texas Medical Association, was keynote speaker at the tenth annual meeting of the Ninth District Medical Society on March 17. Dr. Haden E. McKay, Jr., Humble, Ninth District president, presided at the meeting in Brenham.

Dr. C. E. Southern, Brenham, president of the Washington-Burleson Counties Medical Society, delivered the welcoming address. Other speakers and their features on the program included Dr. Marvin E. Chernosky, Houston, "External Signs of Internal Diseases"; Dr. Ben T. Withers, Houston, "Management of Tonsillectomies"; Dr. T. H. Giddings, "Intracranial Hemorrhage Following Anticoagulant Therapy"; Dr. Raymond D. Pruitt, Rochester, Minn., "Cardiac Arrhythmias and Arrest"; Dr. John L. Perry, Houston, "Choice of Treatment for Malignant Tumors"; Dr. Herman L. Gardner, Houston, "Trends and Developments in Pelvic Surgery"; Dr. Joe W. King, Houston, "Osteoporosis"; Dr. J. Stuart Boren, Houston, "Differential Diagnosis of Scrotal Masses"; and Dr. Marshall G. Henry, Houston, "Head Injuries."

Officers named by the society were Dr. George V. Pazdral, Somerville, president-elect; Dr. Sam R. Barnes,

Trinity, vice-president; and Dr. William E. Sharp, Baytown, secretary treasurer. Dr. Herbert H. Duke, Baytown, was nominated as councilor. Named president was Dr. Irving M. Watson, Jr., Conroe.

Bellville was selected as site for the 1961 district meeting of the society.

Thirteenth District Society Meets in Mineral Wells

Dr. William B. Allensworth, Mineral Wells, was elected president of the Thirteenth District Medical Society when that group held its March 6 meeting in Mineral Wells.

Other officers named were Dr. James A. Hallmark, Fort Worth, vice-president, and Dr. Robert Moreton, Fort Worth, secretary-treasurer, with Dr. Travis Smith, Abilene, being nominated as councilor, and Dr. W. P. Higgins, Fort Worth, vice-councilor.

The program consisted of a discussion by six physicians of the specific points in the Texas Medical Association's Handbook for Delegates which will come before the House of Delegates at the Association's annual session this month. Those participating in the discussion included Dr. W. R. Sibley, Abilene; Dr. Travis Smith, Abilene; Dr. W. P. Higgins, Fort Worth; Dr. James C. Whittington, Eastland; Dr. Robert L. Daily, Wichita Falls; and Dr. Drue O. D. Ware, Fort Worth.

Dr. May Owen, Fort Worth, President-Elect of the Texas Medical Association, attended, as did approximately 40 other physicians representing the various counties in the Thirteenth District.

Second District Society Elects Officers

Doctors from a 21 county area making up the Second District Medical Society met in Midland March 6 to participate in a symposium on "Recent Advances in Management of Surgical and Obstetrical Patients" and to elect new officers.

Dr. Wilton N. Jones, Snyder, was elected president; Dr. Thomas F. Hartley, Snyder, secretary-treasurer; and Dr. William Kenneth Cowan, Colorado City, vice-president. Snyder will be host for the next district meeting.

Speakers included Drs. Mavis P. Kelsey, E. L. Slataper, and W. D. Seybold, all staff members of Baylor University College of Medicine and University of Texas Postgraduate School of Medicine, Houston. Dr. W. S. Parks, Midland, outgoing secretary-treasurer, was moderator.

The future of medicine was the topic of Dr. Franklin W. Yeager, Corpus Christi, President of the Texas Medical Association, when he addressed about 75 physicians and their wives at the evening banquet.

District 11 Meets in Palestine

District 11 Medical Society met February 25 in Palestine.

Featured on the program was Dr. Arthur Grollman, Dallas, professor of experimental medicine, Southwestern Medical School, whose subject was "Newer Diuretics," and Dr. Harold L. Dodson, Houston, associate professor of medicine, Baylor University College of Medicine, whose subject was "Oral Diabetic Therapy."

★ County Societies

County Medical Society Briefs

The *Tarrant County Society* heard Dr. E. Richard Halden, director of the Carter Blood Center, Fort Worth, describe services and policies of that center when it met February 2. "For every unit donated, one unit owned," will be the byword of the institution, Dr. Halden said, and he stated that the center is undertaking organization of the whole area into a giant donor pool in order to insure blood for all.

The speaker was introduced by Dr. Hobart O. Deaton, chairman of the blood bank committee.

During a business session, the group elected Dr. George W. Bean to provisional membership and Dr. Richard C. Schaffer to regular membership.

The society approved the action of its board of directors and mental health committee in recommending hiring of a full-time city-county psychiatrist; notification was to be made to the Hospital District Board.

The group also adopted a resolution stating its opposition to Senate Joint Resolution 41, already passed by the United States Senate, which proposes an international spending program for health research and worldwide distribution of American health personnel.

A letter from the Federal Aviation Agency, which was read, stated an "urgent demand for the employment of a deputy flight surgeon to assist the flight surgeon in carrying out the medical program in this region."

"Cardiac Emergencies" was the subject of Dr. G. E. Colyer, Corpus Christi, when he addressed the *San Patricio-Aransas-Refugio Counties Society* at the Colony Club in Sinton April 6. Co-hosts for the event were Dr. Boyce Elliott and Dr. Richard D. McConchie, Aransas Pass.

Dr. S. W. Bohmfalk, district councilor, spoke on "Medical Ethics and Etiquette" at the society's February 3 session, for which Dr. and Mrs. Daniel R. Baen and Dr. and Mrs. William A. Guynes, Mathis, were hosts at the Sinton club.

The *Bexar County Society* honored six past presidents, Drs. Witten B. Russ, W. A. King, W. H. Hargis, John A. McIntosh, Pat Ireland Nixon, and Charles S. Venable, at its March 8 meeting. Featured talk of the evening, by Dr. A. W. Hartman, was on "The Impact of the Robert B. Green Hospital on the Community."

A society dinner on February 9 was given by Charles Pfizer and Company, Inc. Speaker was Frederick C. Fink, Ph.D., of the Pfizer Laboratories, who discussed problems of susceptibility to antibiotics.

Members of the Bexar society's committee on civil defense, hospital representatives, and the military set up most of a 200-bed emergency field hospital located in San Antonio for training purposes, and then repacked it in the Federal Center building on February 20. A similar exercise will be held in a few months.

The *Dallas County Society*, meeting March 8 in Medical Arts Building auditorium, heard Dr. Burton Combes discuss "New Concepts of Liver Disease," and Dr. G. Tom Shires discuss "Diagnosis and Management of Portal Hypertension."

A second reading of its proposed new constitution and by-laws was given when the *Travis County Society* met on March 15 in Austin. At the February meeting of the group, a resolution opposing Forand-type legislation was unanimously adopted. Dr. W. W. Harris commented briefly on work being done by the Association of American Physicians and Surgeons.

Dr. John A. Wall discussed "Carcinoma of the Cervix" before the *Nueces County Society* on March 8. Dr. Wall, clinical associate professor of obstetrics and gynecology at Baylor University College of Medicine, Houston, is a past president of the Texas Division, American Cancer Society.

The *Lamb-Bailey-Hockley-Cochran Counties Society* made a tour of the new hospital at Littlefield in lieu of a program at its January 26 meeting.

Dr. J. Garrott Allen, professor and executive head of the Department of Surgery, Stanford University School of Medicine, was featured speaker at the March meeting of the *Potter-Randall Counties Society*. His topic was "End Results of Surgery of Cancer of the Breast." Speaker for another recent meeting of the group was Dr. Franklin Ebaugh, Denver psychiatrist, who discussed "Depressive Reactions."

The *Falls County Society* held its March 14 session at Houston's Restaurant and the residence of Dr. J. S. Bussell, Marlin. Speaker was Dr. Samuel Feiner, chief urologist at the Veterans Administration Hospital of that city.

The *Dallam-Hartley-Sherman-Moore Counties Society* recently heard Dr. Isadore Dravin, Amarillo, discuss "Office Endocrinology."

"Present Status of Endocrine Influences Upon the Stomach and Their Relationship to Peptic Ulcer Disease" was the subject of Dr. Seymour J. Gray, also a Ph.D., of Harvard University Medical School and Peter Bent Brigham Hospital, Boston, when he addressed the *Potter-Randall Counties Medical Society* April 11.

When the *Lamb-Bailey-Cochran Counties Medical Society* met in Muleshoe in February, it heard Dr. Ray E. Santos of that city discuss "Urea as a Decongestant in Skull Injuries and Glaucoma."

County Societies Elect Officers

County medical societies in Texas have announced the following officers for 1960:

Atascosa.—President, Dr. Walter H. Joyce, Lytle; secretary-treasurer, Dr. John D. Austin, Pleasanton; delegate, Dr. Joyce; alternate, Dr. John M. Faggard, Poteet; board of censors, all members.

Borden-Dickens-Garza-Kent-King-Scurry-Stonewall.—President, Dr. Carl A. Dillaha, Jr., Snyder; vice-president, Dr. Thomas F. Hartley, Snyder; secretary, Dr. Robert B. Pierce, Snyder; delegate, Dr. Charles Ray Cockrell, Snyder; board of censors, Drs. Hartley, Pierce, and Harry P. Redwine, all of Snyder.

Bowie.—President, Dr. Richard R. Brunazzi, Texarkana; president-elect, Dr. Jean E. Rorie, Texarkana; first vice-president, Dr. Marvin L. Williams, Texarkana; second vice-president, Dr. William S. Tyson, Jr., New Boston; secretary-treasurer, Dr. Richard J. Schneble, Texarkana; delegate, Dr. Charles V. Bintliff, Texarkana; alternate, Dr. Charles Adna Smith, Texarkana.

Brazoria.—President, Dr. John S. Caldwell, Jr., Freeport; vice-president, Dr. G. Bedford Brown, Jr., Angleton; secretary, Dr. Duane Jack Kilian, Lake Jackson; treasurer, Dr. John R. Venable, Freeport; delegate, Dr. W. D. Nicholson, Freeport; alternate, Dr. Ralph E. Gray, Velasco; board of censors, Dr. Gray, Drs. James A. Stewart, Lake Jackson; Dr. G. F. Perryman, Freeport.

Brooks-Duval-Jim Wells.—President, Dr. J. Harold Williams, Alice; vice-president, Dr. Juan C. Gonzalez, Benavides; secretary-treasurer, Dr. Richard O. Albert, Alice; delegate, Dr. Riley N. Riddle, Alice; first alternate, Dr. A. M. Allison, Alice; second alternate, Dr. Glenn T. Howard, Alice; board of censors, Drs. Williams, Howard, and William H. Newkirk, all of Alice.

Caldwell.—President, Dr. W. G. Robertson, Jr., Luling; secretary-treasurer, Dr. Philip A. Wales, Lockhart.

Camp-Morris-Titus.—President, Dr. Charles J. Wise, Naples; vice-president, Dr. William A. King, Omaha; secretary-treasurer, Dr. James S. Leeves, Naples; delegate, Dr. James E. Ball, Mt. Pleasant; alternate, Dr. Robert L. Johnson, Pittsburg; board of censors, Dr. Harry O. Philips, Lone Star; Dr. James F. Lee, Daingerfield; and Dr. King.

Cherokee.—President, Dr. J. H. Kreimeyer, Rusk; vice-president, Dr. Edward L. Mahon, Jr., Jacksonville; secretary, Dr. Thomas H. Cobble, Rusk; assistant secretary, Dr. Leslie W. Ralston, Jacksonville; delegate, Dr. George M. Hilliard, Jacksonville; alternates, Drs. J. Collier Rucker and Victor W. Pryor, both. of Jacksonville; board of censors, Drs. Griff W. Bilbro and V. W. Pryor, Jacksonville; Dr. W. E. Gabbert, Rusk; and Dr. Robert E. Rossman, Alto.

Colorado-Fayette.—President, Dr. James T. Makinson, La Grange; vice-president, Dr. Jones C. Laughlin, Eagle Lake; secretary-treasurer, Dr. Edward T. Williams, La Grange.

Cooke.—President, Dr. James W. Atchison; vice-president, Dr. Howard S. Davenport; secretary-treasurer, Dr. Dan M. Brown; delegate, Dr. Atchison; alternate, Dr. Charles K. Mills; board of censors, Drs. Clu Flu Lusk, Stanley E. Saikin, and Ira L. Thomas, all of Gainesville.

Coryell.—President, Dr. O. Wendell Lowrey; vice-president, Dr. Kermit R. Jones; secretary-treasurer, John T. Brown; delegate, Dr. Lowrey; alternate, Dr. Jones; board of censors, Dr. Lowrey, Dr. E. Elworth Lowrey, and Dr. Jones, all of Gatesville.

Dawson-Lynn-Terry-Gaines-Yoakum.—President, Dr. Cecil B. Knox, Brownfield; president-elect and vice-president, Dr. Louis R. Barnes, Jr., Seagraves; secretary-treasurer, Dr. Keller P. Greenfield, Denver City; delegate, Dr. Douglas B. Black, Lamesa; alternate, Dr. Alfred H. Daniell, Brownfield; board of censors, Dr. Emil H. Prohl, Tahoka, Dr. C. Skiles Thomas, Tahoka, and Dr. Noble L. Rumbo, O'Donnell.

Denton.—President, Dr. Paul F. Glass, Jr.; president-elect, Dr. Harry M. McClendon; secretary-treasurer, Dr. Faul E. Weathers; delegates, Drs. Hal V. Norgaard and Dickson K. Boyd; board of censors, Drs. Norgaard, Gilbert E. Adami, and William A. Remley, all of Denton.

Ellis.—President, Dr. John G. Compton, Jr.; vice-president, Dr. James B. Silman; secretary-treasurer, Dr. Norman L. West; delegate, Dr. Herbert Donnell; alternate, Dr. West, all of Waxahachie; board of censors, Dr. James R. Jeter, Ennis; Dr. Ted G. Estes, Waxahachie; and Dr. Arthur O. Dykes, Italy.

Grayson.—President, Dr. Stanley L. Clayton, Denison; vice-president, Dr. Stanley E. Monroe, Sherman; secretary-treasurer, Dr. W. Herbert Brown, Denison; delegate, Dr. Rene G. Gerard, Denison; board of censors, Dr. Dickson P. Bonner, Sherman; others to be elected.

Gregg.—President, Dr. George W. Tate, Longview; vice-president, Dr. Sam Mack, Longview; secretary-treasurer, Dr. D. D. McDonald, Longview; delegate, Dr. Benjamin Reid Clanton, Longview; board of censors, Dr. Clanton, Dr. Bain Leake, Gladewater, and Dr. D. C. Simmons, Kilgore.

Grimes.—President, Dr. Solon D. Coleman; president-elect, Dr. C. Marius Hansen; vice-president, Dr. L. O. Coleman; secretary-treasurer, Dr. William Scott Conkling; delegate, Dr. Hansen; alternate, Dr. Solon D. Coleman; board of censors, Drs. Everard T. Ketchum, John C. Galbreath, and L. O. Coleman, all of Navasota.

Guadalupe.—President, Dr. John A. Mueller; vice-president, Dr. Leroy E. Weiss; secretary-treasurer, Dr. Herbert G. Liberty; delegate, Dr. Mueller; alternate, Dr. Weiss; board of censors, Drs. Andrew A. Raetzsch, George P. Bachman, and Joseph T. Goetz, all of Seguin.

Harrison.—President, Dr. Roger Q. Harmon, Jr.; vice-

president, Dr. Edgar H. Allen, Jr.; secretary, Dr. James H. Harris; executive secretary, George S. McKay; delegate, Dr. Richard G. Granbery; alternate, Dr. Charles A. Wyatt; board of censors, Drs. Granbery, George E. Bennett, and Maurice H. Murphy, all of Marshall.

Hays-Blanco.—President, Dr. Rugel F. Sowell, Jr., San Marcos; vice-president, Dr. Ray E. Bullard, Jr., Blanco; secretary-treasurer, Dr. William L. Moore, Jr., San Marcos; delegate, Dr. Bullard; alternate, Dr. Sowell; board of censors, Drs. Rugel F. Sowell, Sr., Charles W. Scheib, and Benge Elliott, all of San Marcos.

Jasper-Newton.—President, Dr. Thomas R. Jones, Jasper; vice-president, Dr. John T. Moore, Kirbyville; secretary, Dr. Claude Mattingly, Jr., Jasper; delegate, Dr. Rider E. Stockdale, Jasper; alternate, Dr. A. J. Richardson, Jr., Jasper; board of censors, Drs. J. J. McGrath and Joe W. Dickerson, Jasper, and Dr. Grover C. Winslow, Hemphill.

Kimble-Mason-Menard-McCulloch.—President, Dr. Robert D. Hays, Brady; vice-president, Dr. Dowdell W. Jordan, Brady; secretary-treasurer, Dr. James G. Bodenhamer, Mason; delegate, Dr. B. A. Hallum, Jr., Brady; alternate, Dr. J. P. Anderson, Brady; board of censors, Drs. Bodenhamer, Jordan, and Anderson.

Kleberg-Kenedy.—President, Dr. Bert H. Walling, Jr., Kingsville; president-elect, Dr. Emmett W. Greif, Kingsville; vice-president, Dr. S. Chester Dunn, Kingsville; secretary-treasurer, Dr. Dewey W. Peace, Jr., Bishop; delegate, Dr. William A. Ewert, Kingsville; alternate, Dr. Collier M. Sublett, Kingsville; board of censors, Drs. Peace, Walling, and Lindell E. Ramey, all of Kingsville.

Limestone.—President, Dr. W. Burton Barrow, Mexia; president-elect, Dr. Charles H. Brewster, Mexia; vice-president, Dr. Cecil C. Edgar, Mexia; secretary, Dr. Stanley Cox, Groesbeck.

Lubbock-Crosby.—President, Dr. James G. Morris; vice-president, Dr. Howard R. Hancock; secretary, Dr. A. Lee Hewitt; treasurer, Dr. Clyde F. Elkins, Jr.; delegates, Drs. Otis W. English and Harold Warshaw, all of Lubbock; alternates, Dr. Lowell W. Spikes, Ralls, and Dr. Roy L. Riddel, Jr., Lubbock; board of censors, Drs. Ewell L. Hunt, O. Brandon Hull, and Charles E. Ratcliff, all of Lubbock.

McLennan.—President, Dr. Paul C. Murphey; president-elect, Dr. R. Wilson Crosthwait; secretary, George W. Berry; delegates, Drs. Howard Dudgeon, Jr. and Woodrow M. Avent; alternates, Drs. Merchant W. Colgin and William N. Roddy; board of censors, Drs. Walter B. King, Jr., Ralph L. Coffelt, and J. Ross Shipp, all of Waco.

Milam.—President, Dr. Thomas S. Barkley, Rockdale; vice-president, Dr. Philip M. Young, Rockdale; secretary-treasurer, Dr. L. E. Selden, Rockdale; delegate, Dr. Sidney H. Richardson, Cameron; alternate, Dr. Clifford G. Swift, Cameron; board of censors, Drs. Swift and Elmer O. Smith, Jr., both of Cameron; and Dr. Lawrence E. Hamilton, Rogers.

Montgomery.—President, Dr. I. Emil Carroll; president-elect and vice-president, Dr. William R. Hurst; secretary, Dr. Melvin G. Hutchins; delegate, Dr. Hutchins; alternate, Dr. Deane L. Sadler; board of censors, Drs. E. E. Lenon, I. M. Watson, Jr., and L. F. Brignac, Jr., all of Conroe.

Navarro.—President, Dr. J. H. Barnebee, Jr.; vice-president, Dr. David P. Hansford; secretary, Dr. F. C. Pannill, Jr.; delegate, Dr. Paul H. Mitchell; alternate, Dr. J. Wilson David; board of censors, Drs. Leslie E. Kelton, Jr. and Charles L. Gary, Jr., Corsicana, and Dr. Ivan Terry Sanders, Kerens.

Nolan-Fisher-Mitchell.—President, Dr. Bruce H. Johnson, Loraine; vice-president, Dr. Joe C. Terry, Loraine; secretary-treasurer, Dr. William Kenneth Cowan, Colorado City; delegate, Dr. Tom D. Young, Sweetwater; alternate, Dr. Robert L. Price, Sweetwater; board of censors, Dr. Chester U. Callan, Rotan; Dr. Laurence H. Rudd, Colorado City; and Dr. Francis T. N. Hood, Jr., Sweetwater.

Red River.—President, Dr. Rex L. Edwards, Clarksville; president-elect, Dr. Melvin Marx, Jr., Clarksville; secretary-treasurer, Dr. James L. Wright, Clarksville; delegate, Dr. Earl E. Brooks, Bogata.

Tarrant.—Delegates, Drs. Thomas L. Shields, Mal Rumph, Ray V. Brasher, W. P. Higgins, Jr., and Drue O. D. Ware, all of Fort Worth; alternates, Drs. Harry H. Womack, Robert C. Stow, D. E. Neal, D. E. Compere, Warren W. Moorman, all of Fort Worth; board of censors, Drs. Frederick C. Rehfeldt, Thomas B. Bussey, and John H. Richards, all of Fort Worth.

Walker-Madison-Trinity.—President, Dr. Jesse B. Heath, Madisonville; vice-president, Dr. Eugene M. Addison, Huntsville; secretary-treasurer, Dr. Raymond B. Blalock, Huntsville; delegate, Dr. Sam R. Barnes, Trinity; alternate, Dr. William B. Veazey, Huntsville; board of censors, Dr. Harold H. Thornton, Trinity; Dr. James A. McKay, Madisonville; and Dr. Thomas C. Cole, Huntsville.

Wichita.—President, Dr. Lillard N. Simmons; president-elect, Edwin C. Bebb; secretary-treasurer, Frank S. Browne; delegates, Drs. Joseph D. Hall and Robert L. Daily; alternates, Drs. E. A. Cox and Jack E. Maxfield; board of censors, Drs. Mark E. Huff, James T. Lee, and Joseph Gordon Holt, Jr., all of Wichita Falls.

Wilbarger.—President, Dr. Emory D. Hollar; vice-president, Dr. John B. Hardin; secretary-treasurer, Dr. Franklin B. Steele; delegates, Drs. Alvin L. Borchardt and Raymond A. Lemee, Vernon.

★ Woman's Auxiliary

Mrs. Ramsay H. Moore Takes State Auxiliary Presidency

Mrs. Ramsay Hudson Moore is the forty-third President of the Woman's Auxiliary to the Texas Medical Association, serving for the year 1960-1961. She is the daughter of

MRS. RAMSAY H. MOORE

Mr. and Mrs. W. F. Bassett of Kosse. Her family has lived there about 100 years.

She attended grammar school in Kosse, private school, and Southern Methodist University.

Mrs. Moore enjoys music, gardening, flower arranging, traveling, and her friends. She has a keen appreciation of lovely things, both old and new. She enjoys her home and is a gracious hostess. She likes to do thoughtful and unexpected things for people. Her scholastic interests were piano, voice, art and home economics.

Since her college days at Southern Methodist University, Mrs. Moore has been a conscientious worker in her community. She is known for her organizational abilities, good sense of humor, and belief in good public relations. She tries to be a good doctor's wife, and is always interested in Auxiliary work. Being "just a willing worker" has kept her busy in various civic, community, social, and medical activities. She is a member of the Highland Park Presbyterian Church.

She served on the Dallas Woman's Club board of governors for 3 years. She was corresponding secretary, chairman of the entertainment program teas, children's committee, and memorial service. She has served on the art, membership, yearbook, decorations, and other committees. She was vice-chairman of the Woman's Club work room during World War II and worked with Bundles for Britain. She was a Gray Lady and worked at the Fifth Ferrying Command Base Hospital at Love Field and Ashburn General Hospital at McKinney. She has served as president of the Dallas Browning Club and president of the Lyceum Club, of which she was a charter member. She is a member of the Thalia Club, the Craig Class (an organization which presents outstanding lectures), and the Dallas Southern Memorial Association, having served as secretary and on various committees.

In the Woman's Auxiliary to Dallas County Medical Society she has served as president-elect, president, parliamentarian, and treasurer. She has also served as chairman of the following committees: advisory, budget, courtesy, program, membership, student loan fund, essay, exhibit, identification, memorial fund, and liaison.

In the State Auxiliary, she has served as First Vice-President, Second Vice-President, Fourth Vice-President, and Parliamentarian. She was on the Revisions Committee for two appointments of 3 years each, installed the officers at one of the state meetings, and has been chairman of Memorial Service, School of Instruction, and Memorial Fund.

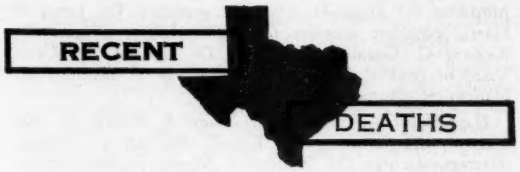
The new President is married to Dr. Ramsay Hudson Moore, a pediatrician who attended Culver Military Academy, the University of Tennessee, and the University of Texas. Dr. Moore is a charter member of the Texas Pediatric Society, a past president, secretary, and councilor. He was one of the organizers and charter members of the Dallas Pediatric Society and is a past president.

Dr. Moore is a fellow of the American Academy of Pediatrics. He served as associate professor of clinical pediatrics at Baylor University College of Medicine when it was in Dallas and now holds a similar post at Southwestern Medical School of the University of Texas.

Mrs. Moore's two sisters also reside in Dallas. One is the wife of the surgeon, Dr. Robert S. Sparkman. The other is Miss Hattie Ford Bassett.

Mrs. Moore, Zelma, or Sister, as many friends know this sparkling personality, is well qualified to handle the demands of the office of President of the Woman's Auxiliary to the Texas Medical Association. She will carry on the traditions of the Auxiliary with graciousness and ability, and will meet new challenges with courage and leadership.

—MRS. EVERETT C. FOX, Dallas.



DR. RUSSELL R. STERLING

Dr. Russell Rhea Sterling, Houston, died February 27, 1960, in Houston. A native of Thorpe, Wis., where he was born on July 24, 1902,. Dr. Sterling attended high school at Stanley, Wis., and received his academic education at the University of Wisconsin. He was graduated from the University of Wisconsin Medical School on June 20, 1927.

In 1927-1928, he was resident house officer at the New England Deaconess Hospital in Boston, and from 1928 to 1930 he studied under a postgraduate fellowship at Cleveland Clinic Hospital, Cleveland, Ohio. A general practitioner and surgeon, he established his practice in Houston in 1931.

DR. RUSSELL R. STERLING

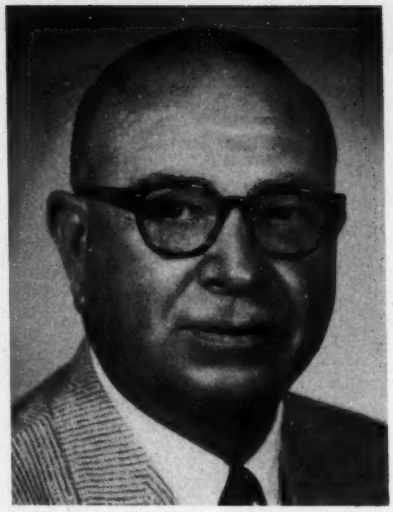
Dr. Sterling was a member of the American Medical Association, the Texas Medical Association, and the Harris County Medical Society. He belonged to Alpha Kappa Kappa medical fraternity, the Knife and Fork Club, and the Briar Club.

Survivors include his wife, Margaret, and a daughter, Miss Peggy Ann Sterling, both of Houston.

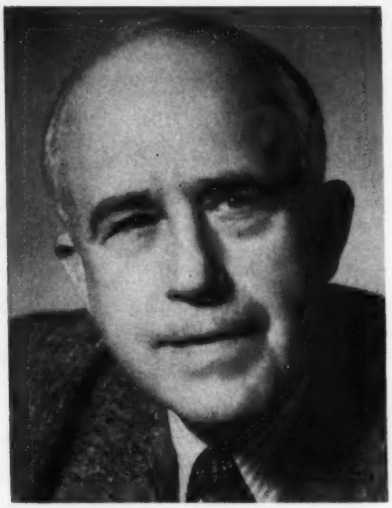
DR. W. E. BARKER

Dr. William Ermon Barker, Longview, died February 5, 1960, following a heart attack in his office.

An orthopedic surgeon, he had practiced in Longview since 1951, moving there from Houston. He also had practiced in Corpus Christi. Born in Gladewater on May 25, 1906, he was graduated from Longview High School and studied at Austin College in Sherman. Following graduation from the Baylor University College of Medicine, he in-



DR. W. E. BARKER



DR. L. J. PICKARD

terned at Jefferson Davis Hospital in Houston. He served his residency in orthopedic surgery at Long Island College Hospital and St. Giles Hospital, Brooklyn, and Jersey City Medical Center.

A member of the American Medical Association, the Texas Medical Association, and the Gregg County Medical Society, Dr. Barker also was a diplomate of the American Board of Orthopaedic Surgery; a member of the American Academy of Orthopedic Surgeons, the Houston Surgical Society, the Clinical Orthopedic Society, the Texas Orthopedic Association, the Western Orthopedic Association, Pi Beta Phi medical fraternity; and was a fellow of the International College of Surgeons.

Survivors include his wife, the former Josephine Lee; a daughter, Miss Patricia Barker, student at North Texas State College in Denton; a son, Wayne Barker, Houston; and two sisters, Mrs. J. W. Sparks, Gladewater, and Mrs. Carl Johnson, Leavenworth, Kan.

DR. L. J. PICKARD

An Abilene physician for 47 years, Dr. Luther James Pickard, 72, died March 2, 1960, following a two-car collision on February 3 in which he was critically injured.

He was listed as the first traffic fatality of Abilene for 1960.

Born in Weatherford on September 13, 1887, Dr. Pickard was the son of J. Tom Pickard and Maria (Kerr) Pickard. He was graduated from Weatherford High School and Weatherford Junior College. Graduated from the University of Texas Medical Branch at Galveston in 1911, he spent a year as an intern at Fordham Hospital in New York City. He served also as an intern at Johnson's Hospital, Fort Worth. Specializing in obstetrics and gynecology, Dr. Pickard began his practice in Abilene in 1913.

A member of the American Medical Association and the Texas Medical Association, Dr. Pickard was a past president of the Taylor-Jones Counties Medical Society. In 1947, he was president of the Abilene Club of that city. His church membership was with the Episcopal Church of the Heavenly Rest, Abilene.

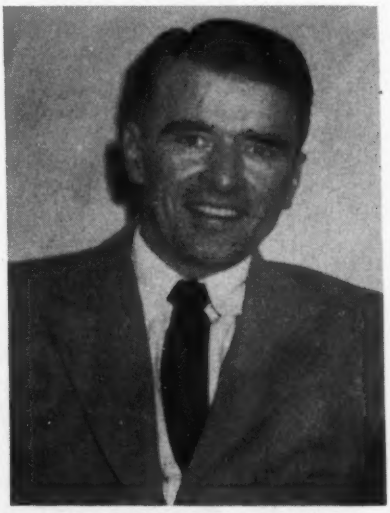
From 1917 to 1919, Dr. Pickard had served as a physician in the Army at Fort Riley, Kan. He held the rank of captain.

Surviving Dr. Pickard are his wife; two daughters, Mrs. Jack Herman of Abilene and Mrs. Enders P. Huey of New London, Conn.; a son, James K. Pickard of Washington, D. C.; and eight grandchildren. Also surviving are two sisters, Mrs. Lucy P. MacKenzie of Weatherford and Mrs. Stuart Chapin of Ashville, N. C.

DR. ROBERT P. GALLAGHER

Dr. Robert Paul Gallagher, Amarillo, died March 5, 1960, in the Veterans Administration Hospital there of multiple sclerosis.

Born August 8, 1914, in Graceville, Minn., Dr. Gallagher attended Graceville High School. He received his premedical training at the University of Minnesota and was



DR. ROBERT P. GALLAGHER

graduated in 1943 from the University of Minnesota Medical School. He served his internship as a part-time staff member of the Health Service at the University of Minnesota. From 1944 to 1946 he served with the Army Medical Corps.

Before coming to Texas in 1948 he had practiced in Ortanville, Minn., where he belonged to the Big Stone County Medical Society. In Texas he was on the staff of the Veterans Administration Hospital.

In Amarillo, Dr. Gallagher founded the Multiple Sclerosis Chapter for the Panhandle. Because of his lengthy and serious illness, he was unable to remain active other than to guide activities of the organization. As a physician, his specialty was fertility and sterility.

Dr. Gallagher held membership in the American Medical Association, the Texas Medical Association of which he became an honorary member in 1954, and the Potter-Randall Counties Medical Society. He belonged to St. Joseph's Catholic Church.

He was married to Miss Esther Elaine Gednetz on April 22, 1946, and the couple became parents of three children, Patricia, Michael, and Molly.

Besides his wife and children, survivors include his mother, Mrs. A. E. Gallagher, Amarillo; a sister, Miss Kathleen Gallagher, Atlanta, Ga.; and a brother, David Gallagher, Dillon, Mont.

DR. S. H. WATSON

Dr. Seaborn Harris Watson, Waxahachie, died January 26, 1960, in a Dallas hospital.

Born October 12, 1878, in Dallas, Dr. Watson was a lifetime resident of Waxahachie, where he practiced medicine for more than 50 years. He was the son of Seaborn Harris and Amanda (Beard) Watson. Educated in the Waxahachie public schools and the University of Texas, Austin, Dr. Watson completed his medical degree at Tulane University, New Orleans, in 1904, after first attending the University of Texas Medical Department in Galveston.

He was a member of the American Medical Association, the Texas Medical Associaton, and the Ellis County Medical Society, which he served as secretary in 1943. In 1932, he was secretary of the Section on Medicine and Diseases of Children for the state organization and he was elected to honorary membership in 1955. He belonged to the Rotary Club and to Kappa Sigma fraternity.

His wife, the former Miss Mamye Mincer, preceded him in death in 1955. She was at one time president of the Woman's Auxiliary to the Texas Medical Association.

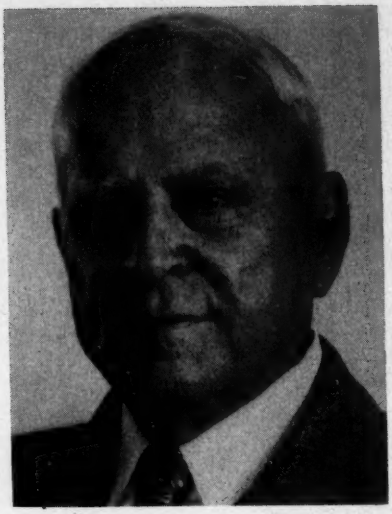
Survivors include two sisters, Mrs. A. B. Small of Dallas and Mrs. E. W. LeBeaume of St. Louis.

DR. RICHARD A. GOETH

Dr. Richard Anton Goeth, San Antonio, died January 1, 1960, at his home in San Antonio. Death was caused by an irreversible arterial failure which was generalized and secondary to arteriosclerosis.

Named an honorary member of the Texas Medical Association and the Bexar County Medical Society in 1951, Dr. Goeth had retired from medical practice in 1958.

Born March 3, 1874, in a log cabin in Blanco County near Cypress Mill, Dr. Goeth was the son of Carl Goeth and Ottilie (Fuchs) Goeth. He was one of a family of five sons and two daughters. Both the log cabin and the family's new home which was completed in 1881 are now Blanco County landmarks.



DR. RICHARD A. GOETH

Dr. Goeth received his preliminary education from private tutors who lived in the new family home. Entering the University of Texas Medical Branch at Galveston in 1891, Dr. Goeth was one of the seven members of the class to complete the first full 3 year curriculum in 1894. His graduation date was delayed until 1895 because he was a minor. Continuing his postgraduate training at John Sealy Hospital in 1895, he received his residency training in 1896 at the New York Polyclinic, where he studied surgery, pathology, and clinical microscopy.

For two short periods, Dr. Goeth practiced in Marion and New Braunfels and from 1896 to 1901, he established his practice in Boerne. From 1901 until 1958, he practiced in San Antonio.

In addition to membership in the Texas Medical Association and Bexar County Medical Society, Dr. Goeth was a member of the American Medical Association and the Southern Medical Association. As president of the San Antonio Automobile Club in the early 1900's, he mapped extensive portions of Bexar, Travis, and other surrounding counties.

He was at one time Grand Lodge Physician for the Fraternal Order of Hermann Sons for the state of Texas, was a member of the Tuesday Musical Club, the Beethoven Choral Society, the San Antonio Casino Club, the San Antonio Country Club, the Travis Club, and the Victory Masonic Lodge. For 14 years, Dr. Goeth was surgeon for the Southern Pacific and Aransas Pass Railroads. His other interests included farming and ranching in which he participated actively in his leisure time.

Of an inventive nature, Dr. Goeth developed and patented an automobile tire pump which utilized power from the automobile in the early days of automobile history.

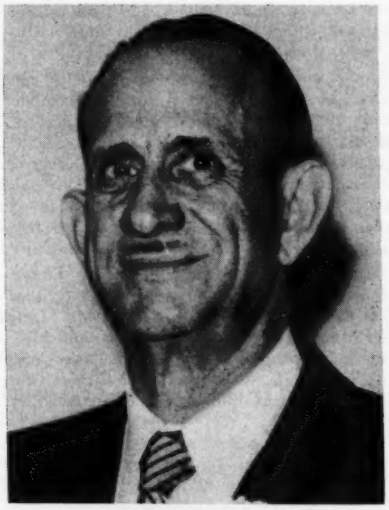
In 1898, Dr. Goeth married Miss Lily Edith Dittmar, and after her death, he married Miss Alma Tips in 1910. At the time of her death in 1955, the couple had been married 45 years. Two children, Richard Louis, now of Miami, Fla., and Lily Edith, now Mrs. Carlton Adams, Jr. of Devine, were born of the first marriage, and Dr. Carl Goeth of San Antonio, was born of the latter. Surviving are the daughter, both sons, and four grandchildren. Dr. Goeth was associated with his younger son from 1937 until his retirement.

DR. L. F. METZ

Dr. Louis Frederick Metz, staff member of the Stamford Sanitarium at Stamford, died February 22, 1960, in his sleep.

Born December 6, 1899 in Trenton, Tenn., Dr. Metz was the son of Louis and Sophia (Eckstein) Metz. He attended Peabody High School at Trenton, and was graduated from Vanderbilt University School of Medicine in Nashville. Completing his internship and residency at the Protestant Hospital in Nashville in 1924, he moved in 1925 to Stamford, where he established his practice.

Specializing in obstetrics and gynecology, Dr. Metz was a fellow of the Texas Association of Obstetricians and Gynecologists. In addition, he was a member of the American Medical Association, the Texas Medical Association, and the Taylor-Jones Counties Medical Society, which he had served as president and as secretary. He was on the board of directors of the First National Bank at Stamford and served as a committee chairman for the Texas Cowboy Reunion and was team physician for the Stamford High School football team. He was a member of Alpha Kappa Kappa medical fraternity.



DR. L. F. METZ

Survivors include his wife, the former Miss Helen Darr of Nashville, whom he married September 5, 1925, in Abilene; two daughters, Mrs. W. C. McDonald of Buffalo, N. Y., and Miss Judith Metz of Midland; a sister, Mrs. Jim Beveredge of St. Louis; and one granddaughter, Kathryn Jane McDonald.

DR. G. D. BOYD, JR.

Dr. Granberry Davis Boyd, Jr., San Antonio, former Bexar County health officer, died at his home January 19, 1960.

A graduate of Southern Methodist University in 1923 and the Baylor University College of Medicine in 1928, Dr. Boyd interned at Robert B. Green Hospital in San Antonio and the Scott and White Clinic in Temple, where he completed his residency in 1931. From February, 1941, to 1946, he was in military service in which he attained the rank of lieutenant colonel.

Born February 23, 1901, in Grandview, he was the son of Granberry Boyd, Sr. and Princess (Eliott) Boyd. He was married July 17, 1928, to Miss Verla Bridgewater and the couple has one son, Granberry Davis Boyd III.

A member of the American Medical Association, the Texas Medical Association, and the Bexar County Medical Society, Dr. Boyd was a general practitioner. For 10 years until 1957, he served as Bexar County health officer.

Dr. Boyd was a member of the Methodist Church.

Surviving are his wife and son; two brothers, H. B. Boyd of Alvin and Charlie Lee Boyd of Grandview.

DR. CHRIS C. MANSELL

Dr. Chris C. Mansell, Lubbock, died January 30, 1960, of melanoma at his home.

Dr. Mansell was born November 2, 1902, in Mineola, Texas, where he received his preliminary education. He attended the University of Texas at Austin and was graduated from the University of Tennessee College of Medicine at Memphis in May, 1928, where he had been a member of the Tennessee Doctors football team. He completed his internship with the United States Naval Hospital at Philadelphia and received postgraduate training at the University of Pennsylvania Graduate School of Medicine in Philadelphia, the University of Iowa at Iowa City, and the University of Berlin in Berlin, Germany. He served actively with the United States Navy for 18 months in 1928 and 1929 and volunteered again for active duty in 1941, serving until 1945. During the latter period he served aboard ship on the Atlantic coast, spent 18 months in the African theater where he was in charge of medical supplies loaded on crafts being prepared for the invasion of Italy and southern France.

A member of the American Medical Association, the Texas Medical Association, and the Lubbock-Crosby Counties Medical Society, Dr. Mansell was chief radiologist at the West Texas Hospital, Lubbock, from 1946 until his death. He also practiced dermatology.

DR. CHRIS C. MANSELL

His other interests included hunting and constructing and refinishing furniture.

Dr. Mansell was married January 9, 1929, to Miss Shirley Lomax of Dallas in New York City. The couple had three children, Chris Mansell, Jr., now deceased, Patricia Mansell Gordon of Moline, Ill., and Susan Mansell.

Surviving are his wife and daughters; two grandchildren, Howard Christopher Gordon and Lisa Jean Gordon; a brother, B. G. Mansell, Fort Worth; four sisters, Mrs. V. L. Owens, Commerce; Mrs. Boatner Willis, Mrs. Sibyl Max, and Mrs. Bruce Beesley, all of Mineola.

Friends of Dr. Mansell have established a Chris Mansell Memorial Fund to aid worthy premedical students at Texas Technological College, Lubbock. Dr. O. W. English of Lubbock is chairman of the fund project, which is being collected through the Texas Tech Foundation.

DR. L. B. S. RICHTER

Dr. Louis Bacon Saunders Richter, Yoakum, died February 27, 1960, of a heart attack at his home. He had curtailed his practice after suffering a heart attack in July, 1959.

Born January 26, 1911, in Shiner, Dr. Richter was the son of Louis Berthold and Elfreda (Beusing) Richter. He attended Shiner High School, Schreiner Institute at Kerrville and the University of Texas at Austin, and was graduated from the University of Texas Medical Branch at Galveston in 1935. His internship was served at Southern Pacific and Jeff Davis Hospitals in Houston.

A general practitioner and surgeon, Dr. Richter established his medical practice in Yoakum on September 6, 1936.

He was married on August 11, 1940, to Miss Helene Louise Kidd of Yoakum at San Antonio.

Dr. Richter was a member of the American Medical Association, the Texas Medical Association, the Inter-County Medical Society, the American Society of Clinical Hypnosis, the American Academy of General Practice, and he had been invited to membership in the American Board of Abdominal Surgeons.

He had been secretary and president of his county society, was a member of Nu Sigma Nu medical fraternity, a Mason, Shriner, and was a member of the Lions Club. His church affiliation was with Holy Cross Lutheran Church and at the time of his death he was a committeeman in the church. Special hobbies he undertook were sailboating, gardening, woodwork, and cooking.

Survivors include his wife; two daughters, Miss Saundra Kay Richter and Stanley Ann Richter; a son, Barrett Richter, all of Yoakum; his mother, Mrs. L. B. Richter of Shiner; and two sisters, Mrs. E. G. Wessels of Houston and Mrs. E. D. Peschel of Brenham.

DR. MINOR L. WILLIAMS

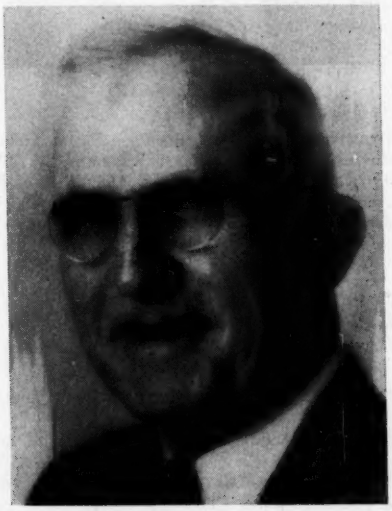
Dr. Minor Lafayette Williams, Robstown, died December 29, 1959, in Corpus Christi after an extended illness.

Son of Mr. and Mrs. John Wesley Williams of Griffithville, Ark., Dr. Williams was born April 23, 1870. He attended the Searcy Military College in Searcy, Ark., and was graduated from the Louisville Medical College in Louisville, Ky., in 1893. Dr. Williams began his medical career in Texas in Kelm, Stanton, and Bishop, before going to Robstown, where he had practiced since 1920.

Dr. Williams activities included helping organize the Robstown Hospital and being an honorary member of the Texas Medical Association and a member of the American Medical Association and the Nueces County Medical Society. He had served the county society as president. He also had held membership in the Navarro, Nueces, and Kleberg County Societies, in addition to holding life membership in the Robstown Masonic Lodge and being a member of the Shrine and the First Methodist Church. Dr. Williams had been city-county health officer in Stanton.

Surviving are his wife, the former Miss Emma Bell of Clarendon, Ark., whom he married in 1894; four daughters, Miss Pansy Williams of Robstown, Mrs. Louise Lindquist and Mrs. Belva Gersback of Dallas, and Miss Maxine Williams of San Antonio; two sons, Talmage Williams of Robstown and M. L. Williams, Jr. of Corpus Christi; and a sister, Mrs. Hallie Collinsworth of Griffithville, Ark.

DR. L. B. S. RICHTER



DR. MINOR L. WILLIAMS